Board of Directors Meeting

To be held 28th November 2017
3:00pm Learning Centre, Maudsley Hospital

AGENDA: Part 1

Opening Matters
1. Welcome, apologies for absence, declarations of interest
2. Minutes, Action log review
3. Chief Executive’s Report

Strategy
4. Research and Development Strategy

Quality & Safety
5. Family and Carers Strategy Update
6. Learning from Deaths

Governance
7. Council of Governors Update
8. Equalities and Workforce Committee Update

Performance
9. Performance Report
10. Finance Report

For Decision
11. Proposal to appoint Altaf Kara, Director of Strategy and Commercial as an Executive Director

For Noting
12. Freedom to Speak Up Guardian – Board Reporting
13. WRES Implementation Plan Year One – baseline metrics
14. Report from previous Month’s Part II
15. Wrap-up and Next Meeting

The next Board of Directors Meeting will be held on 19th December 2017 at 3:00pm, in the Learning Centre, Maudsley Hospital

Please note that minutes from this meeting are a public document and will be published on the Internet and may be requested under the Freedom of Information Act (2000). Any attendee that would like their name omitted from the minutes should discuss this with the minute taker. Note that it may not always be possible to oblige as this is dependent on the persons role and the business being discussed.
MINUTES OF THE HUNDRED AND ELEVENTH MEETING OF THE BOARD OF DIRECTORS OF
THE SOUTH LONDON AND MAUDSLEY NHS FOUNDATION TRUST
HELD ON 31 OCTOBER 2017

PRESENT

Roger Paffard Chair
Kristin Dominy Chief Operating Officer
Alan Downey Non-Executive Director
Rachel Evans Director of Corporate Affairs
Mike Franklin Non-Executive Director
Duncan Hames Non-Executive Director
Gus Heafield Chief Financial Officer
Dr Michael Holland Medical Director
Dr Julie Hollyman Non-Executive Director
Altaf Kara Director of Strategy and Commercial
June Mulroy Non-Executive Director
Beverley Murphy Director of Nursing
Dr Matthew Patrick Chief Executive
Sally Storey Interim Director of Human Resources
Anna Walker Non-Executive Director

IN ATTENDANCE

Colan Ash Head of Risk and Assurance
Godfried Attafua Interim Service Director, Psychosis CAG
Jenny Copley Lead Governor
Simon Darnley Deputy Director, PMIC CAG, and Governor
Angela Flood Governor
Barbara Grey Director, SLaM Partners and QI Service Lead
Marnie Hayward Governor
Kathryn Hill Head of Engagement, Participation and Involvement
Rose Hombo Head of Nursing and Quality (Acute CAG)
Charlotte Hudson Deputy Director of Corporate Affairs
Hugh Jones Clinical Director, Acute CAG
Brian Lumsden Deputy Lead Governor
Gabrielle Richards Professional Head of OT / Recovery
Elaine Rumble Deputy Director, Nursing / Quality (Psychosis)
Gill Sharpe Governor

APOLOGIES

Professor Ian Everall Non-Executive Director

DECLARATIONS OF INTEREST

None

MINUTES

A typographical error at BOD 132/17 was pointed out and the title should be amended to read “Quarterly report on safe working hours for Doctors in postgraduate training”.

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The minutes of the Board held on the 19 September 2017 were otherwise agreed as an accurate record of the meeting. The Chair was content for the minutes to be regarded as signed by him on this date, subject to the correction being made at BOD 132/17.

**BOD 136/17 MATTERS ARISING / ACTION POINTS REVIEW**

Mike Franklin confirmed that he now holds the Emergency Preparedness, Resilience and Response (EPRR) portfolio for the Trust.

Kris Dominy provided an update on the development of the proposed scorecard for Community Teams, which will be piloted by December and brought back to the Board in due course.

All action points had been completed or were on track. Altaf Kara added that he had taken on an action, not represented in the tracker, to develop an estates performance scorecard. This would be ready for presentation by December.

*Action:* Estates dashboard to be scheduled for December 2017 Board meeting.

*Action:* Schedule Community QUESTT dashboard for future meeting.

**BOD 137/17 QUALITY IMPROVEMENT - UPDATE AND WORK PLAN WITH IHI 2017/18**

Owing to technical difficulties, this item did not go ahead but will be integrated into future QI updates to the Board.

**BOD 138/17 PATIENT STORY – SAFEGUARDING**

The presentation was given by Rose Hombo, Head of Nursing and Quality for the Acute CAG, and Elaine Rumble, Deputy Director, Nursing / Quality (Psychosis).

The story of Mr A had been presented to the Board on a previous occasion, but there had been a request for an update.

Mr A had been diagnosed with schizo-affective disorder and type II diabetes. He had a long history of poor mental health and had been admitted to hospital on a number of occasions. When not in hospital, Mr A was under the care of the community teams.

Mr A had a history of disengaging from services, stopping his medication, failing to comply with his diabetes care and going missing, which meant that it was very difficult to offer consistent treatment.

In May 2012, Mr A was admitted under Section 2 of the Mental Health Act. His medication was re-introduced, and he progressed fairly well. In August 2012, he became unwell due to his diabetes and was transferred to Kings College Hospital, where he was stabilised and started on insulin treatment before he was transferred back to the Maudsley Hospital.

Mr A was discharged three weeks later. Four weeks after that, Mr A was found dead in his accommodation. The coroner noted that his death was, in part, due to "gross failures" and neglect.
While there were things which were done well in both the inpatients and community environments, poor communication between the ward and community services was flagged as a problem. The discharge summary did not get to a GP – neither team identified that Mr A did not have a GP – or to the community team. The risk assessment did not reflect Mr A’s physical health needs and no-one from the community team attended the final ward round pre-discharge, nor was there a 7-day follow-up visit post-discharge. The suitability of Mr A’s accommodation as not assessed (he had moved out of borough to unsuitable accommodation) and there was no home visit. There was no documented evidence of MDT discussions, an agreed plan of action or outcomes of agreed interventions.

As a result of review of practice, changes have been made to the way complex patients are managed both on the ward and in the community. Seven-day follow-ups are mandatory and are audited, and minimum standards for community contact while a patient is on the ward have been set. Pre-discharge planning meetings with HTT and community teams have been implemented. Management of patients on Community Treatment Orders has been improved and managing physical health has been made a priority on the wards. Contact and communication with GPs has been improved, as has the turnover time for discharge notification and summary.

Admission and discharge checklists have been standardised within the Acute CAG, and there is now a function to establish who a patient’s GP is within the Acute Referral Centre. Clinical formulation meetings have been set up to review complex cases and the interface between community teams, care coordinators and consultants have much improved.

Julie Hollyman noted that the investigation report did not seem to comment on the leadership and management team involved in Mr A’s case and the lack of urgency in following up with someone who frequently does not attend meetings and disappears for long stretches of time. It was explained that a significant issue in this case was that Mr A’s history of disengagement meant that the team may have been complacent in following up because of his erratic behaviour. When incidents like this happen, the focus of the investigation is to look at problems with structures and processes, not with individuals.

Julie Hollyman agreed that patient disengagement may lead to complacency on the part of staff, but expressed concern that the approach outlined suggests that no-one is taking responsibility for the failures identified. Michael Holland explained that given the events took place in 2012, it would be difficult to identify individual responsibilities now and that, in this instance, the failures were in the systems and processes rather than with any individuals. Julie Hollyman stressed that leadership accountability at team level should still have been addressed by the report.

Beverley Murphy drew a comparison between the way the Trust works now compared to the way it worked then. Zoning meetings, which bring collective thought around patients, are now in place and there is no opportunity to become complacent.

Mike Franklin felt that Mr A’s case triggered many alarm bells – his arrest, no mention of family or friends, no GP – all of which should have been picked up by the system. He sought assurance that there are systems in place to prevent this from happening again. This is not the first story of this nature that the Board has heard, and there must be some urgency to rectifying the systemic issues.
Matthew Patrick agreed that this was a terrible event, a Never Event, with clear questions around safety. He asked whether enough thought is given to high risk patients where it is clear that every box on the checklist should be ticked.

Anna Walker felt it important to recognise that it is not possible to say that something like this will never happen again. However, the Psychosis CAG has done what it can to prevent it. Whether these lessons have been understood across the organisation is a different matter. In terms of accountability, even if there was not an individual at fault, team leaders must take responsibility collectively.

Beverley Murphy flagged that physical health is being tracked and that performance has improved over the last twelve months. The CQC has commented that, in some areas, the physical health work goes above and beyond expectations, whereas in other areas improvements are needed. There needs to be consistency across the Trust. She again stressed the importance of zoning meetings, where the needs of complex patients are rigorously attended to. This consistency and assurance was not in place at the time of this incident.

Duncan Hames thanked the presenters and said that although a significant time has passed since these events, it is important to hear this story and understand the lessons learned for the purposes of corporate memory. He asked what assurance there is that the interventions made as a result of the lessons learned have remained in place and are resilient. The response was that Consultants and Teams Leaders are routinely asked for assurance of what they have in place.

Roger Paffard thanked the presenters for attending what was no doubt an uncomfortable session, but stressed the importance of the Trust asking itself these difficult questions.

The Board

Noted the Report.

BOD 139/17 JOINT INITIATIVES WITH KING’S HEALTH PARTNERS

Professor Sir Robert Lechler attended the meeting to present a King’s Health Partners update.

He reported that the institutes programme is moving forward well, with major improvements in cardiology, haematology, diabetes and neurosciences, and Programme Boards (chaired by Non-Executive Directors) have been established.

KHP is holding partnership discussions with the Royal Brompton Foundation Trust, who see real gains in what they do in terms of working more closely with SLaM.

KHP is also responding to the Government’s Life Sciences Industrial Strategy, as well as looking ahead to reaccreditation as an Academic Health Sciences Centre (AHSC). Prof Sir Lechler said that there are sites around the country that operate without an AHSC badge, and that there is a query as to why the competition for AHSC designation should be re-run. However, in his view, the designation creates a sense of accountability that adds drive to progress, as well as raising profiles and assisting the recruitment of talent and resources.
Other KHP work includes cross-partner informatics to improve the interoperability of data systems to improve mental / physical healthcare; a value-based healthcare programme linking with Trust transformation programmes to share learning and progress pilot project; and the publication of twelve outcomes books.

Prof Sir Lechler stressed that mental health is at the heart of the institutes programme, and each strand depends on SLaM as the champion and driver on remaining true to mental health.

He reported that the mind and body programme is doing well, and that work is underway to determine a model for scaling up the screening programme, including physical health at SLaM.

Fundraising is at an exciting stage and mental health will be one of the flagship schemes of the next campaign.

KHP is very keen to develop the idea of a Denmark Hill Campus, the key driver for which is a shortage of student space.

Mike Franklin asked whether Brexit had had an impact on international students. Prof Sir Lechler said that thus far there has been no impact on student numbers but that there are difficulties in recruiting academics and there is a risk of losing existing ones too.

Roger Paffard asked if the Centre for Translational Informatics is going ahead, which Prof Sir Lechler confirmed. The project slowed down because there was a query around whether it needed to be bigger, but it has now been decided that it doesn’t. Costs are currently being put together and a final decision on whether to refurbish or rebuild will be made in the next couple of months. Matthew Patrick stressed that decisions need to be made soon as the discussion has been going on for some time.

Anna Walker asked about the Child Mental Health Unit, which she had assumed was not going ahead as she had not heard about it, as it had been included in this presentation. Matthew Patrick explained that the project is forging ahead as part of KHP’s flagship fundraising programme. Roger Paffard clarified that it is now referred to as the Children and Young People’s Institute programme, so the change in terminology may be the source of this confusion.

The Board

Noted the Report.

BOD 140/17 CHIEF EXECUTIVE’S REPORT

The Chief Executive’s report was taken as read.

Matthew Patrick thanked everyone involved in organising this year’s Staff Awards; it was a terrific day and a good opportunity to celebrate the nominees and winners.

As of 2 October, the South London Mental Health Community Partnership (SLMHCP) is managing Tier 4 CAMHS specialist inpatient provision across South London. This is an important development. The new model of care format allows the Trust to make decisions independently about provision across the area and this has led to positive conversations about bed provision.
Matthew Patrick confirmed that it is intended to develop the Denis Hill unit at the Bethlem Hospital with two PICU beds and six adolescent HDU beds.

On the issues of Trust finances, Matthew Patrick thanked everyone involved for the enormous amount of work undertaken to make £60m in savings / cost reductions over the last two years. He has reinstituted Chief Executive Assurance meetings to look at cost saving programmes alongside regular PACMANs and Portfolio Boards.

The Board

Noted the Report.

BOD 141/17 DEVELOPMENT OF SLAM DIGITAL STRATEGY

Stephen Docherty and Nicola Byrne attended to present this item.

Stephen Docherty explained that the report sets out a strawman three-year strategy for digital services and that a steer is sought from the Board so that the proposals may be finalised and brought back at a later date to be arranged.

Roger Paffard highlighted concerns raised by community care teams during NED visits about the appropriateness of digital solutions. There is a consistent theme of inadequate IT resource. Stephen Docherty outlined the strategy’s aim to engage across the organisation and to get the basics right. Ideally, a third party would be brought in to look at how to optimise the delivery of desktop services, which also presents the opportunity to work across the South London Mental Health and Community Partnership to standardise that offering, especially for those who work across Trusts. This can be expressed more explicitly in the strategy.

Kris Dominy asked that the Operations Directorate has an opportunity to comment on any new scorecard developed for Digital Services. She also emphasised the need for clarity around the use of GDE funds, as any such investment must be matched by the Trust. Under current financial constraints, a compelling narrative must be available to explain why this investment is being made when cost reductions are being implemented elsewhere. Nicola Byrne explained that SL@M Connect, a new initiative for staff engagement, is being established and is a vehicle for communication. Any matched funding from SLaM towards the GDE programme is being taken from within the existing digital services (IT) budget and no additional funding is being asked from SLaM over the life of the programme (3 years).

Julie Hollyman referred to the request for the Board’s comment on “direction on the governance of the new digital strategy” and sought clarification of what this meant. Stephen Docherty clarified that there is a view that governance of the digital strategy could be tied in with governance of the QI programme, as the two are closely linked. Michael Holland agreed to take this issue away and bring back a recommendation.

Action: Michael Holland to make a recommendation on QI / Digital Strategy governance when item returns to the Board.

Gus Heafield emphasised the importance of the strategy being clinically-led and, to an extent, service-user and community-led. The solutions put forward must not simply be about technology, but recognise cultural change and include data and knowledge management.
Anna Walker sought clarity of outcomes in the final strategy paper, as well as clear measurements of success. Improvements in this arena will underpin improvements in meeting quality targets. Stephen Docherty explained that SLaM has been assigned benefits realisation support from NHS England, which means that strategy development will be outcomes-driven.

Altaf Kara advised that the next iteration of the strategy should focus on user experience, and also on how it relates to population health. Stephen Docherty agreed that more work needs to be done in that area to understand needs and desired outcomes.

Duncan Hames supported Roger Paffard’s comment regarding community services; at a visit to Croydon University Hospital, he was informed that there is no access to SLaM systems from there, or vice versa. Is it necessary to wait for systems integration or is it possible to duplicate them so that people working between sites can do their jobs properly? Nicola Byrne said that the problem in Croydon had been addressed, but noted the wider point. In relation to the question of governance, Duncan Hames felt that combining QI and the digital strategy would have merit in terms of challenging initiative fatigue.

June Mulroy wished to focus on getting the basics right and asked to see some separation of what will assist those struggling with ICT and what falls into research and development. She also asked to see a connection with the estates strategy. Stephen Docherty confirmed that it had been anticipated that mobile working would lead to a reduction in the size of the estate, but that the mobile working programme had been deferred, although now the Trust has an opportunity to fully digitise the workforce (using GDE funds) which will enable mobile working. He added that funding has been received to extend wifi to 100% of the estate (coverage is currently at 60%) which should help with mobile working.

**Action:** The final draft of the strategy will be brought back at a later date.

**The Board**

**Noted** the Report.

**BOD 142/17 VENTURING PRINCIPLES**

Altaf Kara set out the purpose of the paper, namely to set out the Trust’s draft principles for venturing in commercial ‘non-core’ areas such as international expansion, private care or commercialisation of property, and to ask for the Board’s input to inform the next iteration of the document.

Julie Hollyman asked that “quality” is well-defined and suggested that the Trust should think about what it is asked to deliver, considers whether it has the expertise to do it and whether it can deliver it.

Roger Paffard asked whether the principles would be specific to every project; Altaf Kara thought that the top-level principles would probably be universal, but the granularity would depend on the project.

Alan Downey agreed that it was a good start, but that more elaboration was required. There should be clear reference to protecting reputation and brand and that any
activity which would cause detriment to that would be a red line. It should also be clear that the Trust will not use NHS money to fund non-NHS, loss-making ventures, but that is not to say that it cannot invest in profit-making ventures where it may take time before any profit is made.

June Mulroy pointed to the absence of governance in the principles. The Trust ought to have the freedom to govern whatever it is it is trying to do, and whether it can may depend on the laws of a specific country. It should not be taken for granted that SLaM will have that right.

Mike Franklin agreed with Alan Downey's concerns about brand and reputation, and emphasised the need to have a principle around being able to demonstrate the benefits of any activity on the local population (whether directly or indirectly). The Trust must also be in a position where it has the flexibility to reassess if situations change.

Anna Walker asked where the decision-making authority would lie in deciding whether the principles were met.

**The Board**

Noted the Report.

**BOD 143/17 CQC RE-INSPECTION REPORT – ADULT COMMUNITY PATHWAY**

Elaine Rumble (Deputy Director, Nursing / Quality (Psychosis)), Debbie Garlick (Head of Nursing & Education, Psychological Medicine Management Team), Simon Darnley (Deputy Director, PMIC CAG), Godfried Attafuwa (Interim Service Director, Psychosis CAG) attended to present this item.

This CQC inspection differed from the previous inspection in scope and detail, given the limited number of the teams looked at the last time as well as CQC having developed criteria significantly, but the outcome of the re-inspection is nevertheless disappointing. The Inspectors broadly confirmed what was already known, which was that there had been some deterioration since the last inspection.

Major issues flagged in the report include the provision of risk assessments and care plans. A particular issue was identified on the Early Interventions team, and since the inspection resource to that team has been increased.

Godfried Attafuwa said that staff are very disappointed by the rating, but recognise the key issues in the report. Following the visit, they have reviewed what needs to change. There is variability in the way that community teams work; some work well and some less so. There is a focus on making delivery consistent and ensuring that structures are robust enough. Work has already started, and the teams are looking forward to delivering quality. There is, however, an issue around conversations that need to be had with the Commissioners.

Simon Darnley reported that there have been ongoing problems with risk assessments and care plans. PMIC has taken a fundamental approach by starting training programmes from the beginning, holding interactive training sessions about what makes a quality risk plan. They are also putting in place a strict audit tool so that clinical service leads will complete 10 audit cases per month. Each care coordinator will discuss a minimum of one in detail per month. They will audit care plans which will then come to borough meetings.
Some of the “Should Do's” in the report are difficult. For example, “patients should have access to psychological therapies without undue delay in line with best practice guidance”.

Kristin Dominy referred to resources being put into Croydon. It is anticipated that the review of community services and delivering services though the borough should strip out duplicated effort. However, there are some things the Trust is doing in Croydon which are being done at risk. She, Beverley Murphy and Michael Holland are working together on this. Through multiple changes in the health community, there is a need to reconstruct what community services can offer. The Trust is at risk in Croydon without these additional resources.

Anna Walker expressed at view that the Trust should be recompensed for the additional resources which have been put in place. It would not be right to mask where a borough is not commissioning the Trust for resources it is providing. Beverley Murphy expects the Quality Sub Committee to go through the improvement plan in some detail.

Mike Franklin was concerned about risk, which had not been addressed by this presentation. He also wanted to know if there are people who need services who are not going to get treated. Beverley Murphy said that the inspectors recognised that everyone would be allocated a worker and would not be left on a waiting list.

Gus Heafield has raised with NHSI the lack of performance data on mental health. More can be done to raise the profile of services and shortfalls by publishing more data.

Matthew Patrick asked for a timeframe on putting the issues highlighted in the report right. Beverley Murphy explained that many actions are already in place and there is close liaison with the QI team. Performance has been compromised on some teams more than others, such as the Early Intervention teams and the broader community teams, and that is where the focus lies. In some areas, the problems are with practice, in others it is resources, and in others it is about documenting process.

Kris Dominy emphasised her own accountability, alongside Michael Holland and Beverley Murphy, for implementing a timetable for improvement.

Duncan Hames asked why the CQC was not persuaded to give a lower score under “Well Led”; Beverley Murphy explained that the CQC had felt that the Trust demonstrated that it had oversight but not enough to drive improvement, meaning that it was not well led. A view was taken that that was harsh, and the Trust was able to evidence – in writing - oversight happens and how it joins up.

Beverley Murphy alerted the Board to updates required to the Trust’s registration and sought delegated authority to update and vary that registration to the CQC.

**The Board**

**Noted** the Report.  
**Approved** delegated authority to Beverley Murphy to update the Trust’s registration.

**BOD 144/17 COUNCIL OF GOVERNORS SEPTEMBER UPDATE**

Marnie Hayward attended to present this item.
A joint meeting of the SLaM and Oxleas NEDs and Governors was held on 12 October. Governors were very interested to hear about the five shared care pathways that are being developed across the three Trusts and to gain a true sense of the spirit of collaboration between key stakeholders and the desire for each pathway to ‘be the best.’ Governors look forward to the resultant positive impact on the quality of services.

In relation to QI, whilst there is an acknowledgement of the requirement for better communication, increased co-production and training for service users/carers and Governors generally, these elements are not mentioned in the 17-18 workplan. Governors would like assurance that there is a mechanism for ensuring the QI priorities identified are monitored for progress. In addition, although Governors had a discussion with the NEDs in a meeting prior to the Board about this, going forward they would like some clarity on whether the Trust’s significant investment into QI is providing value for money.

Marnie Hayward thanked Harold Bennison and Kris Dominy, on behalf of the Governors, for the Performance Report, which draws together a lot of very useful information in an accessible format. Governors are concerned about how the “increasing pressure on community services” (2.2) and “20% increase in presentation to A&E MH liaison teams” (2.2.1) will impact on community staff caseloads, staff health and wellbeing and patient outcomes.

In relation to the Quality Sub Committee quality dashboard, Governors are concerned about the increase in new serious incidents over the last few months.

On behalf of the Lead Governor, Marnie Hayward informed the Board that Governors intend to write to all local MPs in the near future to say that more funding is required for mental health services and that such funding should be ring fenced.

While Governors acknowledge that staff have worked hard to address most of the issues identified in the September 2015 CQC inspection, Governors are concerned that many new issues have been identified. Although the inspection report noted that senior managers had already identified many of the concerns raised and improvement plans are in place, Governors have been raising - and NEDs have been highlighting - for some time the substantial pressures on community staff. Governors will continue to seek assurance that staff are being supported to deliver the required improvements in the fundamentals of safe, high quality services such as appropriate risk assessments and person-centred care. Importantly, Governors will also be seeking assurance that there are the appropriate governance structures in place to ensure that those improvements are sustainable.

**Action:** The Board will respond to the issues raised by the Governors in this report.

**The Board**

**Noted** the Report.

**BOD 145/17 QUALITY SUB COMMITTEE SEPTEMBER UPDATE**

The report was taken as read.

**The Board**
Noted the Report.

**BOD 146/17 AUDIT COMMITTEE SEPTEMBER UPDATE**

The report was taken as read.

Duncan Hames drew attention to the Council of Governors’ appointment, at their September meeting, of Grant Thornton as the new external auditor.

The Board

Noted the Report.

**BOD 147/17 FINANCE AND PERFORMANCE COMMITTEE OCTOBER UPDATE**

The report was taken as read.

Kris Dominy reported that this was the 21st consecutive day where there were no out-of-area placements across the acute and crisis care pathway for any borough. Pressure in the acute system, however, remains very high and the impact of winter is being experienced very early this year. There has been an increase in Mental Health presentations in all four EDs that the Trust serves.

Alan Downey observed that the financials show that the Trust is still on course to meet its control total, but asked at what cost that challenge is being met. Given the CQC re-inspection report, failure to consistently meet basic ICT requirements (or many) basic ICT requirements for front line staff and not meeting performance indicators on IAPT, the question regarding whether the Trust was maintaining its focus on quality rather than the control total was relevant.

Matthew Patrick responded that if there were to be a choice, quality would always prevail. Gus Heafield added that he has been briefing NHSI about the decisions the Trust is having to make in order to meet the control total. The issues are around the scale of Cost Improvement Plans and the size of QIPP.

June Mulroy requested that this remained a consideration for next year’s control total.

**BOD 148/17 BUSINESS DEVELOPMENT AND INVESTMENT UPDATE**

The report was taken as read.

The Board

Noted the Report.

**BOD 149/17 PERFORMANCE REPORT**

The report was taken as read.

The Board
Noted the Report.

**BOD 150/17 FINANCE REPORT & Q2 NHSI REPORT**

The report was taken as read.

**The Board**

Noted the Report.

**BOD 151/17 CONFLICTS OF INTEREST POLICY & GIFTS AND HOSPITALITY POLICY**

The report was taken as read.

**The Board**

Noted the Report.

**BOD 152/17 FREEDOM OF INFORMATION ANNUAL REPORT 2016-17**

The report was taken as read.

**The Board**

Noted the Report.

**BOD 153/17 REPORT FROM PREVIOUS MONTH’S PART II**

The report was taken as read.

**The Board**

Noted the Report.

**BOD 154/17 WRAP UP, NEXT MEETING AND DATES FOR 2018**

Roger Paffard apologised that the meeting had overrun considerably, owing not only to IT issues for the QI item, but also because of the thorough discussion around the Patient Story. Mike Franklin felt that it may not be possible to hear a Patient Story every month, but that it is an important and valuable item.

The date of the next meeting will be:
Tuesday 28 October 2017 – 3.00pm; ORTUS Learning Centre, Maudsley Hospital, Denmark Hill, London, SE5 8AZ

Representatives of the press and members of the public were asked to withdraw from the remainder of the meeting having regard to the confidential nature of the business to be transacted, publicity on which would be prejudicial to the public interest. (Section 1 (2) Public Bodies Admission to Meetings Act 1960
## Public Board meeting 28 November 2017 – Action points

<table>
<thead>
<tr>
<th>Ref</th>
<th>Issue/Board Paper</th>
<th>Action</th>
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<td></td>
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<td>Workforce subcommittee from October 2017 to oversee the Recruitment and Retention data and develop KPIs for insertion into the Performance Report.</td>
<td>SS/JH</td>
<td>Oct 2017</td>
<td>Equalities and Workforce Committee inaugural meeting held 31 October 2017. KPIs in development.</td>
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<td>Retention and Recruitment</td>
<td>Chair to arrange meeting with the new Chair Croydon CCG to express concern over access to MH services in that Borough.</td>
<td>RP</td>
<td>Oct 2017</td>
<td>Complete.</td>
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<td>2</td>
<td>Matters Arising</td>
<td>Updated Physical Health Strategy to come to the Board by November 2017</td>
<td>BM</td>
<td>Nov 2017</td>
<td>On Board agenda for December 2017.</td>
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<td>Mortality Report</td>
<td>Increased data analysis requested in regard to the data over the use of Sections 2, 3 and 136 Mental Health Act powers</td>
<td>BM</td>
<td>Jan 2018</td>
<td>On track</td>
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<td>Mental Health Law Management Annual Report. April 2016 - March 2017</td>
<td>Update on Croydon Contract refresh to come to the Board after SMT discussion</td>
<td>GH</td>
<td>Nov 2017</td>
<td>To be included in November Finance report to Board.</td>
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<td>Overview of Working Age Community Mental Health</td>
<td>Update on Croydon Contract refresh to come to the Board after SMT discussion</td>
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**October 2017 meeting**

| 6   | Matters Arising | Estates dashboard to be scheduled for December 2017 Board meeting. | AK | Dec 2017 | On agenda for December 2017 |   |
| 7   | Matters Arising | Schedule Community QUESTT dashboard for future meeting | KD | Jan 2018 | Add to agenda for January 2017 |   |
| 8   | Development of SLaM Digital Strategy | The final draft of the strategy will be brought back at a later date. | RE | Jan 2018 | On agenda for January 2018 |   |
| 9   | Development of SLaM Digital Strategy | Michael Holland to make a recommendation on QI / Digital Strategy governance when item returns to the Board. | RE | Jan 2018 | On agenda for January 2018 |   |
| 9   | Council of Governors September Update | The Board to respond to the issues raised by the Governors in this report. | RE | Nov 2017 | Issues addressed in detail at Quality Working Group meeting 14/11/17 |   |

**Code:**

- **Green** – completed
- **Amber** – on schedule
- **Red** – not on schedule
REPORT TO THE TRUST BOARD:  PUBLIC
NOVEMBER 2017

<table>
<thead>
<tr>
<th>Title</th>
<th>CHIEF EXECUTIVE’S REPORT</th>
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<tbody>
<tr>
<td>Author</td>
<td>Dr. Matthew Patrick</td>
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Purpose of the paper

To inform the Board about significant issues affecting the Trust.

A - Royal College of Psychiatrists Awards

I am delighted that two of our psychiatrists have won prestigious Royal College of Psychiatrists Awards. The Psychiatrist of the Year 2017 prize was awarded to Dr Sridevi Kalidindi – a fantastic achievement. Sri is a Consultant Psychiatrist in Rehabilitation and Recovery, as well as the South East London Sustainability and Transformation Plan Mental Health Lead and a Visiting Senior Clinical Lecturer at the IoPPN. As the former Chair of the Faculty of Rehabilitation and Social Psychiatry at the Royal College of Psychiatrists, she has collaborated to set the national direction of rehabilitation psychiatry. She is a co-author of national Joint Commissioning Panel for Mental Health Commissioning Guidance for Rehabilitation Services and co-developed the national Rehab service standards. She was presented with her award by Norman Lamb MP, the Liberal Democrat former health minister.

In addition, Professor Oliver Howes received the ‘R N Jajoo Memorial Academic Researcher of the Year’ Award. A Consultant Psychiatrist, Oliver runs a service at the Trust for people with refractory psychoses. He is Professor of Molecular Psychiatry at the IoPPN and the London Institute of Medical Sciences, Imperial College London. His research into a new approach to treating schizophrenia as a disease of the immune system was recently covered in The Guardian.

My warm congratulations to them both.

B – Black Thrive

Many of you will have seen that the Guardian featured an interview with Jacqui Dyer MBE, a Lambeth councillor and Chair of Black Thrive. Jacqui discusses race and mental health, following her appointment as advisor to the Government on its review of the Mental Health Act.
The Trust is a core member of Black Thrive Lambeth, which aims to bring together different organisations and voluntary groups to change how we work so our local black community can thrive and improve their mental health and wellbeing. Jacqui Dyer and Patrick Vernon (Black Thrive Director) will be presenting to the Council of Governors in December and will be joining a future Board to present on their action plan.

C – Cavendish Square Group

In early November, I attend an excellent meeting of the Cavendish Square Group. This is a collaboration of the ten London NHS Trusts responsible for mental health services. At this meeting, we met the new Mental Health Lead for the Metropolitan Police Service, who was clearly engaged and committed to developing good partnership working between the capital’s mental health providers and the Metropolitan Police.

D – Visit of the Secretary of State – Jeremy Hunt

At the end of October, the Trust was visited by the Health Secretary, Jeremy Hunt. He met with a range of SLaM staff and discussed issues around mental health in the workplace with our Medical Director, Michael Holland, and our Director of Nursing, Beverley Murphy – the video is available on YouTube. His visit, along with those to local trusts Guy’s and St Thomas’ and King’s, coincided with the publication of an independent review of mental health and employers. He tweeted that he was impressed by our relentless focus on safety and quality and the work on reducing violence.

E - South London Mental Health and Community Partnership Appointments

I am pleased to announce two important new appointments as part of the South London Mental Health and Community Partnership (SLMHCP). A Clinical Director – Dr Diana Cassell - has been appointed to the CAMHS New Model of Care. We have also appointed a Managing Director for the SLMHCP Hub – Jeremy Walsh. Both are from the South West London and St George’s NHS Trust and we are looking forward to working with them and making further strides in progressing this important partnership.

F – Overspill Beds

Finally, I would like to extend my considerable thanks to all our staff who have succeeded in significantly reducing our use of private overspill beds down to close to zero. This has been down to some extraordinary hard work and fantastic team-working between the Acute services, Community services, the ARC and others. Significantly reducing our use of overspill beds is vital to ensure the best quality care for our service users. I would like to thank each member of staff involved for their hard work and determination.

Dr. Matthew Patrick
REPORT TO THE TRUST BOARD: PUBLIC
28 November 2017

<table>
<thead>
<tr>
<th>Title</th>
<th>Research and Development Strategy 2017-18</th>
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<tbody>
<tr>
<td>Author</td>
<td>Fiona Gaughran and Gill Dale</td>
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<tr>
<td>Accountable Director</td>
<td>Michael Holland</td>
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Purpose of the paper

Research and Development needs to be core business for the Trust, and is central to the QI agenda. The R&D Strategy has been developed in consultation with key internal stakeholders, with the aim of ensuring that we are developing care that is based on research evidence, that gives every patient the opportunity to participate in research, and that develops research and evaluation skills across all our professional staff groups. The R&D Strategy will be reviewed annually and progress reported to the Board.

NHS England has the following mandate: 'The Department of Health requires us to promote and support participation by NHS organisations, patients and carers in research funded both by commercial and non-commercial organisations, so that the NHS supports and harnesses the best research and innovations and becomes the research partner of choice'

The Board is asked to approve the R&D Strategy for SLaM.

Executive summary

R&D is central to SLaM’s Quality Improvement (QI) agenda. The paper sets out our strategy for R&D following consultation with SLaM Strategy Executive and R&D Committee.

Key guiding principles:
- Research at the core – we will seek to ensure that all our service users are offered the opportunity to participate in research appropriate to their interests.
- Translating research into clinical practice – and vice versa – we will continue to seek ways to promptly and effectively translate our research findings into tangible benefits for patients.
- Identifying research priorities – Many clinical areas have embedded strong research programmes informing local, national and international practice but there are also unanswered clinical and service questions that research could inform, including those identified through the quality improvement loop whereby research gaps and priorities will be identified. Some priority areas already identified through consultation are identified in the paper.
- Building research capacity - we will seek to develop research and evaluation skills across all professional groups.
- Ensuring the highest possible standards - all research is undertaken to the highest scientific and ethical standards through effective research governance and management.
- Reducing discrimination and stigma - we will actively promote the social inclusion of people with all forms of mental illness.

Our R&D aims and objectives:
- To maintain a rich and diverse research portfolio addressing SLaM’s priorities.
- To incentivise research activity and develop a research-active work force throughout the Trust.
- To secure sustainable funding to support research.
To effectively measure our research activity and meet key external R&D performance indicators.
To augment recruitment of research participants.
To maintain effective R&D management and governance.
To enhance communication pathways for R&D.

Committees where this item has been considered

<table>
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<tr>
<th>Date</th>
<th>Committee / Meeting</th>
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<tbody>
<tr>
<td>23/03/2017</td>
<td>R&amp;D Committee</td>
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<tr>
<td>03/05/2017</td>
<td>Strategy Executive</td>
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Research & Development Strategy 2017-18

1. Introduction

The South London and Maudsley NHS Foundation Trust (SLaM) provides the widest range of NHS mental health services in the UK as well as substance misuse services for people who are addicted to drugs and alcohol. The Trust is in a position of considerable strength as a research-focused organisation: as well as the extensive opportunities for engaging its service users in research at every level, the Trust benefits from strong academic partnerships as well as access to state-of-the-art research facilities and a wide portfolio of R&D funding streams. R&D is central to SLaM’s Quality Improvement (QI) agenda, which is the basis on which we can improve the lives of the people and the communities that we serve, developing care that is based on research and evidence.

SLaM has a historic association with its close academic partner, the Institute of Psychiatry, Psychology and Neuroscience (IoPPN) at King’s College London. The IoPPN is Europe’s largest centre for research in psychology and psychiatry.

The partnership has a statement of common purpose:

“SLaM and the IoPPN are committed to working together to promote mental wellbeing and to establish the best possible treatment and care for people with mental illness and their family members. We shall do this by promoting excellence in research and teaching to advance understanding of the causation, prevention and treatment of mental illness and related disorders, and by developing the best service models for the community. We shall pass on this knowledge to those who can benefit from it: locally, nationally and internationally.”

SLaM’s approach also reflects the mission of our Academic Health Science’s Centre, King’s Health Partners:

“King’s Health Partners pioneers better health and well-being, locally and globally, through integrating excellence “in research, education and training, and patient care.”

Our Clinical Academic Groups (CAGs) are central in taking forward SLaM’s research endeavours. SLaM holds a large research portfolio, much of which is currently led by IoPPN investigators. We seek to optimise the productivity, recruitment and impact of these research activities but also to address new opportunities of strategic importance to SLaM’s clinical services to be taken forward by research-active staff in all professional groups within the Trust.

This R&D Strategy demonstrates the importance that SLaM places on ensuring that research underpins the delivery of the highest possible standards of clinical care.

2. Key guiding principles

2.1 Research at the core

Research is fundamental to driving better clinical services and improving treatments, and SLaM’s care pathway development through the QI agenda is underpinned by quality research evidence. SLaM has the highest research profile of any mental health Trust in the UK, and a key Trust objective is to ensure that our research portfolio grows, along with associated research income. We will ensure that all our service users
are offered the opportunity to participate in research appropriate to their interests but also place them at the centre of our research endeavour. We actively encourage service user involvement in the research process itself, through collaboration with researchers in the design, implementation and oversight of research, such as through membership of the Service User Research Enterprise (SURE) at IoPPN/SLaM and representation on the Trust R&D Committee.

2.2 Translating research into clinical practice – and vice versa
We will continue to seek ways to promptly and effectively translate our research findings into clinical applications, enhancing the transfer of knowledge from research findings into clinical practice and service development, not just within our own Trust, but nationally and globally. This work will streamline pathways to allow the translational science produced by our NIHR Biomedical Research Centre in particular to inform developments in practice, which are then introduced, refined and evaluated through our extensive clinical-academic partnerships until they reach the point where the now evidence-based practice enters quality improvement programmes, making changes through the QI methodology, ‘the model for improvement’

Reciprocally, we will develop research pathways to allow us to answer key questions in clinical practice, informing our work in SLaM and that of mental health practitioners across the globe.

2.3 Research Priorities
The Trust is seen as world leading in a wide range of clinical fields. Many clinical areas have embedded strong research programmes informing local, national and international practice but there are also unanswered clinical and service questions that research could inform. Some of these will be identified through the quality improvement loop whereby research gaps and priorities will be identified. Areas of strong current clinical academic productivity are priorities to support, but we also need to also identify teams where there is scope to increase research activity. Each CAG will be asked to nominate priority research areas with particular clinical relevance to that CAG or the Trust in their annual business plans.

In discussion with SLaM’s R&D Committee and Strategy Executive the following broad priority areas for research have been identified, many of which are also strategic areas for our NIHR Maudsley BRC:

- New models of care (including primary care for mental health)
- Health economics
- Implementation science and health service delivery
- Population Health (including early intervention in all areas, with a longer term perspective on prevention
- Mental / Physical health interface, which is a key focus of the NIHR Maudsley Biomedical Research Centre as well as King’s Health Partners under its Mind and Body programme which seeks to join up mental and physical healthcare
- Comorbidity
- Personalised medicine (including genomic medicine)
- E-health / digital health
- Mental health across the lifespan
- Ethnic diversity and mental health
- Mental health of vulnerable groups – e.g., those with interactions with the criminal justice system; looked after children; people with learning disabilities

Commercial studies are also a priority for the Trust. We will work with our academic partners across KHP to define the processes, engage more Trust staff in recruiting to commercial studies and to increase recruitment numbers year on year.

2.4 Building research capacity
We will seek to develop research and evaluation skills across all professional groups. Our CAGs are the ideal vehicle to promote research as part of every health professional’s remit, affirming research as a valued activity and ensuring that their service users are aware of opportunities to participate in research. Many CAGs are already developing infrastructure to support research and there is opportunity for shared good practice.
2.5 Ensuring the highest possible standards
We require that all research in our organisation is undertaken to the highest scientific and ethical standards through effective research governance and management, led by the joint R&D Office of SLaM and IoPPN. We will ensure that the Trust:

- fully meets the requirements of the Health Research Authority's UK Policy Framework for Health and Social Care Research (which replaced The Research Governance Framework in October 2017) both as a research site and as a sponsor of research.
- optimises the processes whereby research is approved, governed and facilitated through effective research management support.

2.6 Reducing discrimination and stigma
We will actively promote the social inclusion of people with all forms of mental illness, and seek to reduce the discrimination and stigma associated with mental health issues.

3. Our research aims and objectives

3.1 A rich and diverse research portfolio addressing SLAM priorities
We are committed to ensuring that SLAM retains its position as the UK’s leading mental health Trust, recognised across the world for its clinical and research excellence. The Trust has a diverse research portfolio that encompasses all of its Clinical Academic Groups as well as its geographic span. However, some services are more research-active than others, giving the opportunity for growth. Whilst a high proportion of SLAM’s research activity is led by IoPPN clinical academics, bringing kudos, value and income to both organisations, there is also an untapped opportunity to support SLAM staff to take more active roles in leading research. SLAM, through its CAGs and supported by the NIHR Clinical Research Network (CRN), has the ability to identify research priorities and questions driven by the needs of the Trust’s clinical services, as well as opportunities to extend our research activities to particular geographic areas of the Trust where there has been less research activity historically.

3.2 Sustainable funding to support research
Research is financially supported through several mechanisms. It is essential that we have clear and sustainable R&D funding streams to ensure that our research endeavour can underpin and be fully embedded within our clinical resource. A mixed portfolio of activity is best to spread the risk should some funding routes become inaccessible, which should include:

- National Institute for Health Research (NIHR) Portfolio Studies – supported though NIHR–approved funders such as NIHR, MRC and key charities. Prompt recording of recruitment essential.
- Supporting the work of NIHR Senior Investigators
- Core infrastructure funding through the NIHR Maudsley Biomedical Research Centre (SLAM-KCL) and the NIHR / Wellcome Trust King’s Clinical Research Facility (CRF) (contracted via SLAM)
- Other non-commercial studies
- Commercially-sponsored studies

These streams cover a mix of biomedical research (the main context being through the BRC and CRF) and more applied, later-stage research through various programmes such as NIHR Programme Grants for Applied Research and NIHR Research for Patient Benefit and the Collaborative Leadership for Applied Health Research Centre (South London). We have particular strengths in leading and hosting such programmes with the exception of commercially-sponsored studies, where our portfolio is small. Our relative lack of commercial studies in part reflects the low level of investment into the mental health arena by the pharmaceutical industry. However we are building our collaborations and partnerships with industry through the BRC, who with the IoPPN have now created a Centre for CNS Therapeutics, designed to increase the number of industry sponsored trials in mental health. The new SLAM-KCL Centre for Translational Informatics (CTI) introduces a fresh perspective on commercial research, focusing not on traditional pharmacological trials but instead on digital innovations.
3.3 Strengthening NIHR R&D income
Under NIHR, R&D funding from the Department of Health (DH) provides direct support for research and infrastructure schemes, including research grants and Biomedical Research Centres (BRCs); SLaM has been very successful in all of these in collaboration with IoPPN.
In addition to the schemes that provide direct funding for research there are two NIHR funding sources that provide Trusts with support based on the amount of research activity:

- Local Clinical Research Network (LCRN) funding based on numbers of participants recruited into NIHR Portfolio studies, and
- NIHR Research Capability Funding which is based on income from NIHR grants, BRC, and NIHR Senior Investigator awards coming through the Trust.

These funding streams carry different expectations in terms of how they are used and how they are accounted for. They also carry differences in terms of future risk and how they can be influenced in future years. SLaM currently disperses the majority of the above two R&D funding income streams into CAGs so that each CAG has the potential ownership and control of its future R&D income position. This arrangement is currently being updated (see section 3.5). Each CAG will be asked to increase their portfolio recruitment year on year and to create a rolling three-year plan to manage predicted changes in recruitment numbers, for example when projects end.

We will continue to seek to enhance SLaM’s funding through the different R&D mechanisms. We envisage that the CAGs will play a key role in this, bringing together clinicians and researchers strategically. RCF funding can be optimised by encouraging NIHR grant applications through SLaM as well as more applications for NIHR Senior Investigators (from existing NIHR Investigators where individuals receive part salary funding from an NIHR grant or the BRC). NIHR have recently introduced a cap of £4 million for RCF funds. Our CAGs therefore need to actively enhance LCRN funding by encouraging clinical teams to assist with patient recruitment. An important opportunity to grow our R&D income is for SLaM to act as a recruitment site for NIHR Portfolio projects led by other centres.

Excess Treatment Costs (ETCs) are the costs of delivering a treatment in a service context after the research has stopped and are calculated by comparing the cost of an experimental treatment with treatment as usual. The DH expectation is that these costs are covered through ‘normal commissioning arrangements’ however it has always been challenging obtaining such monies from the PCTs and now the CCGs. We will continue to lobby on the major block that securing ETCs puts on conducting research. This is especially problematic in mental health because of the types of interventions – e.g. the cost of trial therapists tends to be greater than that of a medication for example.

3.4 Measurement of research activity
The quality and impact of research is presented annually as part of the KHP CAG outcomes booklets. Additionally, the research quality of our academic partners is assessed via the Research Excellence Framework. Income for research is dependent on grant funding and patient recruitment. The latter requires our academic partners to ensure that all eligible studies are registered with the Clinical Research Network and that all researchers record each participant usually within a week of recruitment. The main quantification of research activity within SLaM will be recruitment to time and target of portfolio studies. CAGS will also be asked to report on their achievements in contributing to the evidence regarding the Trust priority research areas, (see section 2.3).

3.5 Incentivisation of research activity within the Trust
Optimising research activity and related income will require targeted incentivisation of research activity within the Trust. At present the bulk of R&D income is distributed to the CAGs, but there is variability in the effectiveness of the incentivisation strategies used between the CAGs. We have spoken to the CAGs for evidence of good practice in this regard and have developed a financial flow chart to illustrate the planned structure of R&D Expenditure within the Trust (see Annex 1). From the incomes as outlined in sections 3.2 and 3.3, a proportion will continue to be top-sliced to support the R&D Office and related finance costs; a
proportion will be transferred to IoPPN to support SLaM R&D; we will also establish a number of new competitively-appointed fixed-term posts with the aim of attracting R&D grant funding to meet Trust strategic priorities; we will create competitively-appointed fixed-term sessions for clinicians to lead on recruitment to portfolio studies within the Trust; and we will create a strategic research capability fund to allow for strategic in-year support of research meeting the Trust priorities and not otherwise funded. The remainder of the CRN and RCF funding will be directed towards clinical teams, to support new research hotspots and grow existing research activity. This funding, from 2018/19 will be adjusted according to research activity.

3.6 Investment in research
The Trust will need to invest to increase R&D activity, including investments in people and, where needed to ensure competitiveness, infrastructure. Such investments will be decided upon following consideration of each case on its merits, in terms of return in the widest sense.

3.7 Augmenting recruitment of research participants
As well as being at the core of clinical research, patient recruitment into research studies is an important metric that is used to inform our network funding allocation (based on activity under NIHR Portfolio studies). We shall seek to augment our recruitment position in the following ways:

- Increasing the number of studies that drive up recruitment:
  - Maximising the number of studies that encourage researchers to recruit through SLAM – and this means making the SLAM CAG landscape attractive to researchers
  - Actively encouraging the conduct of studies that are eligible for the NIHR Portfolio – this directly impacts on our LCRN funding allocation
  - Actively encouraging the conduct of interventional studies (higher financial weighting than observational)
  - Participating as a recruitment site in non-KCL/SLaM led studies – currently at a low level.

- Augmenting patient recruitment into research by encouraging staff to sign up patients to Consent for Contact (C4C) and encouraging researchers to use C4C to recruit patients.

- Undertaking feasibility assessments for each study to ensure that realistic time and target recruitment numbers are set.

- Maximising recruitment to each study – through introducing CAG key performance indicators for recruitment to time and target, and by adding LCRN support where possible, to maximise the likelihood that each study will meet its recruitment target

- Ensuring that all studies where SLAM recruitment can be claimed are declared as being linked to SLAM by the research team – noting that participant recruitment also includes staff studies, focus groups, sample collection as well as patients receiving an intervention (as outlined above).

3.8 Management of Research and key R&D performance indicators
NHS Trusts are required to meet national requirements for the initiation and delivery of research and it is essential that SLAM is positioned optimally to meet these metrics. These include the ‘70 day metric’ for the initiation of clinical trials, CRN recruitment targets and annual reporting for BRC and CRF as well as RCF annual reporting. Performance in these metrics is supported by the R&D Office although delivery depends on the actions of the research teams and the clinical services hosting the research studies. There is a complex interaction of teams and activities that coalesce to influence the Trust’s performance and, through R&D management, CAGs and the SLAM R&D Committee we will seek to streamline this.

We will work with the Trust to agree research management priorities at a CAG level, with R&D incorporated into CAG Strategies, including management of CAG R&D budgets in relation to current and planned research activity; prioritisation and approval of research activity; research targets; key metrics, including recruitment numbers and numbers of local principal investigators; mapping of research activity and data collection systems. Separate CAG metrics for clinical trials and collaboration with industry will be developed as a Trust strategic priority which, as well as supporting the development of next generation treatments for mental illness will increase the diversity and resilience of our research funding portfolio.
Research performance is also measured by acknowledgement of organisations on research publications, and researchers with either substantive or honorary SLaM contracts should routinely acknowledge their affiliation with SLaM on all their publications.

3.9 A research-active work force
We will support and guide our staff in their research endeavours and steer individuals towards appropriate research training options. This will be facilitated through several approaches including the training opportunities provided by the BRC, opening up research training and development opportunities at IoPPN to SLaM employees, making good use of training opportunities via the KHP Clinical Trials Office as well as resources offered by the LCRN such as the training pack for principal investigators. The SLaM Education and Training Department are working to optimise uptake of research training opportunities and minimise duplication.

Clarification of the new Trust R&D funding structures and training opportunities will pave the way for discussions with Trust clinicians about the ongoing support they would welcome in doing research as part of their routine practice. This will in turn inform approaches to IoPPN/ BRC/ CLAHRC about access to facilities, web-support, honorary academic titles, mentoring and career development.

3.10 Effective R&D management and governance
The R&D strategy and direction of SLaM is led by the R&D Director and supported by the joint R&D Office of SLaM and IoPPN, as well as the R&D team within SLaM Finance, led by the R&D Finance Business Partner. The R&D business of the Trust is overseen by the SLaM R&D Committee, which reports to the Trust Board through the R&D Director. Given that Research and Development is a major unique selling point of the Trust as well as the substantial Trust income deriving from research, it is essential that R&D is strategically integrated within the Trust's governance and management systems.

The R&D Office manages research governance and research contracts functions for SLaM and is resourced largely through SLaM's NIHR R&D income streams. The Office is headed by the Director of Research Quality who is funded jointly by SLaM and KCL. The increased external requirements for governance and metrics reporting has required some growth in the team. There is a continuing need to keep this under review to ensure that the R&D Office is fully equipped to continue to attain the strongest performance in achieving external performance metrics, and thus maintain the Trust's research income.

The R&D Office is committed to ensuring that all research taking place in SLaM meets quality, governance and regulatory requirements. It will continue to review its systems and processes, seeking opportunities for efficiency and streamlining, including harmonization of approaches with KHP partner R&D Offices so as to provide the best support for researchers.

3.11 Research communication
We will work with the SLaM Director of Communications to enhance the research communication pathways, including communications channels, frequency, content and audience working collaboratively with our close partners in the communications departments in the BRC, IoPPN, CLAHRC and KHP to ensure that all of SLaM's stakeholders are aware of the often ground-breaking research coming from the Trust.

4. Measuring the effectiveness of the R&D Strategy
The R&D Strategy will be reviewed annually, with a report provided to SLaM Board in November / December of each year.

The following metrics and milestones will be used to measure the effectiveness of the strategy:
<table>
<thead>
<tr>
<th>R&amp;D Strategy Measures</th>
<th>Metric / Milestone</th>
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<tbody>
<tr>
<td>R&amp;D embedded as core Trust business</td>
<td>• R&amp;D activity increasing in more clinical teams and across geographical areas of Trust;</td>
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<td></td>
<td>• R&amp;D embedded in SLaM core strategy and seen as key element of Q.I. agenda;</td>
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<tr>
<td></td>
<td>• R&amp;D core functions fully resourced to deliver strategy and meet contractual and governance requirements;</td>
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<td></td>
<td>• R&amp;D presence on SLaM intranet and internet with key guidance to support research</td>
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<tr>
<td>Strategic use of R&amp;D funding</td>
<td>• R&amp;D income clearly managed and allocated to support activity;</td>
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<td></td>
<td>• R&amp;D income used strategically to incentivise research activity</td>
</tr>
<tr>
<td>Building SLaM’s research workforce</td>
<td>• Increase number of SLaM staff involved in research;</td>
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<td></td>
<td>• Develop menu of research training opportunities for SLaM staff;</td>
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<td></td>
<td>• Develop research career pathway for clinicians;</td>
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<td></td>
<td>• Increase number of SLaM Principal Investigators;</td>
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<td></td>
<td>• Increase number of SLaM staff with research identified as part of job plan</td>
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<tr>
<td>Enhancing R&amp;D income opportunities</td>
<td>• Engage with national consultations on NIHR income streams such as the future of RCF and excess treatment costs;</td>
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<td>• Maximise recruitment (see below);</td>
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<td>• Increase number of commercial studies;</td>
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<td></td>
<td>• Increase number of research grants secured by SLaM staff;</td>
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<td></td>
<td>• More NIHR Senior Investigators</td>
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<tr>
<td>Recruitment of SLaM service users into research studies</td>
<td>• Increase recruitment to NIHR Portfolio studies;</td>
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<td></td>
<td>• Increase recruitment to commercial studies;</td>
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<tr>
<td></td>
<td>• Increase SLaM patients approached for Consent for Contact (C4C)</td>
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<tr>
<td>PPI involvement</td>
<td>• Establish meaningful PPI involvement in R&amp;D management processes</td>
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<tr>
<td>Acknowledgement of SLaM on research publications and media communications</td>
<td>• Increase number of papers and media communications from KCL-employed honorary staff acknowledging SLaM.</td>
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<tr>
<td>R&amp;D Governance and management</td>
<td>• Effectively measure our research activity;</td>
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<tr>
<td></td>
<td>• Meet contractual reporting requirements;</td>
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<td></td>
<td>• Research meeting national regulatory and governance requirements;</td>
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<td>• National metrics optimal</td>
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SLaM R&D Funding pathways

CAGS
(CRN and RCF funding proportionally allocated); from 18/19 increase or decrease depending on activity
Purpose of the paper

This paper provides and update to the Board on the progress made over the last 12 months in implementing the Trust Family and Carers Strategy. The paper also outlines proposed and planned activities over the next 12 months. The appendix highlights the achievements from the last 12 months across the Clinical Academic Groups.

The board are asked to note the contents of the update.

Executive summary

The Family and Carers Strategy Update provides assurance to the board that the Trust is implementing the key elements of the Family and Carers Strategy. It sets out a range of activities that have been undertaken at a Trust wide level and CAG level (in the appendix) much in partnership with families, friends and carers. The update highlights how much partnership working there is with services and friends, families and carers and a joint sense of purpose.

The key activity of this year has been the introduction of the Carers Engagement and Support Plan. This is an excellent example of cross organisational working as it brought together the Director of Social Care, the Head of Engagement, Participation and Involvement, CAG Carers Leads, the Head of Communications and the Clinical Systems Transformation Lead.

Looking forward to 2018, the Trust will undertake the programme of work within the Acute CAG which will allow it to become a member of the Triangle of Care membership scheme. This means that the Trust has been able to identify itself as an exemplar of working effectively with friends, families and carers. This and the repeat of the 2015 carers benchmark across all other services will provide the platform for the next Family and Carers Strategy to be developed by 2019.
1. Introduction

The Trust’s commitment to support friends, families and carers of people using its services is outlined in the Family and Carers Strategy.

The Family and Carers Strategy is underpinned by the following vision:

**Families and Carers will be valued and supported throughout their contact with our services. As far as possible we will work collaboratively with families and carers recognising them as expert partners in care. Our aim is to improve the experience of all who come into contact with our services and improve health outcomes of the local population.**

The strategy has five implementation priorities and the remainder of this report outlines progress against these priorities both Trust wide and CAG based (in the appendix).

2. Implementation Priorities update

Specific activities that have been achieved over the last 12 months for each of the following Implementation priorities for each of the Clinical Academic Group are detailed in the Appendix at the end of this paper.

2.1. Friends, Family and Carer Involvement

The Trust is committed to ensuring that friends, families and carers, can be involved in the care of their loved one as much as is practically possible, recognising this requires flexibility and sensitivity.

In addition, the Trust is keen for carers to be involved in the business of the Trust through the Involvement Register. There are active arenas in all CAGs such as the Service User and Carer Advisory Committees as well as the Trust-wide Family and Carers Committee.

Over the last 12 months the Family and Carers Committee has reviewed and refreshed the Terms of Reference and as a consequence of this there is now a carer co-chair.

The Trust held its annual *Family and Carers Listening Event* in June which was well attended by carers and had the theme of “Putting Carers in the heart of Quality Improvement”. Four borough based carer listening events will be held over the autumn/winter.

As the Trust undertakes the activity required to become a member of the Triangle of Carer this will be overseen by a subcommittee of the Family and Carers Committee and chaired by the carer Co-chair.

The Trust is currently running the Service User and Carer Leadership programme via the Recovery College.

Carers are regularly involved in delivering training to staff either through SUITE (Service Users in Training and Education) or the Recovery College.
2.2. Informing Friends, Families and Carers

The Trust recognises the importance of keeping carers informed and up to date. *The Family and Carers Handbook* has been refreshed and updated and the new copies are widely available throughout the Trust. A new carer’s poster advertising the right to a Carers Assessment has been developed, printed and circulated widely across the Trust. An additional poster setting out the Carers Charter has also been developed and is available for wards and teams to download from the intranet. The Head of Engagement, Participation and Involvement has regularly attended Carers Forums in Lewisham, Southwark and Lambeth to give updates to those attending.

The Trust is also keen to receive feedback from friends, families and carers and through the Family and Carers Committee a separate PEDIC Carers survey has been developed and is currently being piloted in the Mental Health Older Adults and Dementia CAG. The survey will also be piloted in the acute wards in preparation for the Triangle of Care benchmarking exercise.

The Carers survey will help wards and teams identify potential QI projects to improve the friends, family and carer experience of services.

2.3. Supporting Friends, Families and Carers

All CAGs now have an identified Carers Lead and the majority of wards have a Carer’s lead that is available to give support, information and advice the families, friends and carers as well as to staff.

The major initiative undertaken over the last 12 months has been the development of a Carers Engagement and Support Plan (CESP). The CSEP is for anyone who has identified themselves as a carer and records any communication issues, asks if the right level of support has been given with regard to the mental health condition of the cared for person, asks if information has been given about the type of support available, and asks if information about the role of the key health professional has been given. The carer is also given information on how to access a Formal Carers Assessment. The aim is to have 70% of identified carers having a CESP. To date over 1000 have been recorded on EPJS. To support the introduction of CESP a communications plan was developed and implemented through the internet.

The Recovery College offers a range of courses that are helpful to friends, families and carers.

2.4. Developing staff to work with Friends, Families and Carers

The importance of working with carers and understanding the perspective of carers is included in the Trust Induction and provided by SUITE. A Carers Leads network for the Acute CAG has been set up and the first task for the group is the development of a carers lead role description. The intention is over time for all CAGs to have a Carers Leads Forum.

A Carers and Confidentiality training film has been produced and the training package to go with it is currently being piloted. The training will be rolled out across the acute CAG to support the Triangle of Care benchmarking exercise.

2.5. Working in Partnership

The majority of the activity outlined above has been undertaken in partnership with friends, families and carers. The PEDIC Carers Survey was developed by a sub group of the Family and Carers Committee which comprised off both carers and staff. The *Carers and Confidentiality* film was developed in partnership with the scenarios in the film were written by carers. The annual
Listening Event was a co-produced event in terms of identifying the theme and developing the programme. Many of the CAG specific activities outlined were undertaken and/or delivered in partnership. As more QI projects are developed that focus on Carers there will more opportunities for partnership working.

3. Future Activity

Over the next 12 months the focus centrally will be on the following:

3.1. Embedding the Carers Engagement and Support Plans across all CAGS to ensure that the target of 70% of identified carers is achieved (recognising that some services have minimal contact with carers e.g. IAPT)

3.2. Overseeing the programme of work the Trust will undertake to join the Triangle of Care Membership scheme and giving specific support to the Acute CAG as it undertakes the self-assessment benchmarking exercise

3.3. Undertake and analyse the repeat of the benchmark that was undertaken in 2015 to support the launch of the Family and Carers Strategy across all services other than the Acute CAG. This will allow the Trust to identify where progress has been made and what is still outstanding. This in turn will support the development of the next Family and Carers Strategy which is due in 2019.

3.4. Support the roll out of the PEDIC Carers Survey across the CAGs which have the most carer contact e.g. Acute, Mental Health Older Adults and Dementia, Psychosis and CAMHS

3.5. Support the Carer Co-chair to undertake their role

3.6. Provide support to QI teams wanting to work with Carers.
APPENDIX

The following pages have been provided by the Patient and Public and Involvement Leads from each of the Clinical Academic Groups. They highlight the depth, breadth and richness of the activity supporting the five Implementation Priorities of the Strategy over the last 12 months.

1. Friends, Family and Carer Involvement

Child and Adolescent Mental Health Services (Marianne Caitane)

Supported Discharge Service and the CAMHS Forensic Psychology service jointly run a Parents Plus Adolescent course for Parents and carers from both service requiring additional support – this is partnership work, supporting parents and carers and informing families and carers.

Southwark CAMHS have run parent focus groups alongside the children’s council.

Southwark Parent Led ADHD group.

Lewisham ADHD parent support group.

Special Educational Needs parent initiated and parent- led support group called Shining Stars.

Psychosis (Jane Lyons)

Westways rehabilitation unit at the Bethlem site held an open day for carers in December 2016. Carers said they really valued the quality of care, communication and support that the team provides. They appreciated that the whole staff team including leads (consultant, ward manager, occupational therapist, psychologist and practice development nurse) and family workers came in on a Saturday, reflecting the importance of the event and those attending.

Early Intervention teams offer wellbeing events for families and individuals to recognise their hard work. Last year the Southwark team (STEP) won a Smile fund bid and a group of 14 carers went to the OXO tower for afternoon tea followed by bowling, while in the Lewisham team (LEIS) four carers have been successful in a Let’s Smile bid for a spa day.

The Psychosis CAG involvement advisory working group has carer members who, along with the service user members, advise the CAG Executive on embedding involvement across services. A recent meeting discussed the mental health carers’ forums being developed by carers with the local carers’ centres and how we could build SLaM engagement with them.

Psychological Medicine and Integrated Care (Alice Glover)

At a strategic level: Carers are members of the monthly service user & carer advisory group which liaises with senior managers & clinicians about developments within the CAG. The carer members highlight issues relating to family & carers and bring a carers perspective to discussions. The carers in the group are also members of local carers support groups and forums.

At a service level - carers are involved in peoples care e.g. some specialist and psychological therapy services offer family therapy. - In some services carers are routinely invited to a session / assessment / review to give their perspective on the service user and their issues. There are some examples of carers being involved in setting up carers support group. e.g.: Eating disorders Outpatients.

Acute (Alice Glover)

At a strategic level Carers are members of the monthly service user & carer advisory group which liaises with senior managers & clinicians about developments within the CAG. The carer members highlight issues relating to family & carers and bring a carer perspective to discussions. The carers in the group are also members of local carers support groups and forums.
At a service level: some wards hold carers surgeries. The PEDIC carers survey has been piloted in the wards. This gives carers an opportunity to feedback about their experience. One ward offers visitors the opportunity to fill in a carers feedback card.

Mental Health of Older Adults and Dementia (Nula Conlan)

The CAG invests substantially in Carer engagement. The nature of the client group means that a substantial amount of work is done with carers of our service users.

The CAG has an active Service user and Carer Advisory Group. A carer from SUCAG sits on the CAG Exec. Soon to be joined by another carer.

Other work includes Inpatients – Carer to carer support groups on four wards monthly – issues raised are discussed with the ward manager/staff team as well as fed back to SUCAG.

Behavioural and Developmental and Addictions (Cath Collins)

Inviting in Carer Organisations into River House to see how we work and for them to promote their services to us – Lambeth Carers came in May 2017 to meet Ward Managers, Southwark Carers and Croydon Carers to be invited.

Support to carers from our team of Social Workers at River House who play a key role in working with the families forging and maintain links and offering support to them.

Carers Information boards on each ward with Families and Carers Handbooks available on all wards.

On-going monthly carers and families group on the National Autism Unit (NAU) facilitated by the social worker on the ward, all carers/families invited to attend – outside speakers, mutual support offered.

Plans on how to roll out the Carers Engagement and Support Plan in Addictions in line with each borough contract.

2. Informing Friends, Families and Carers

Child and Adolescent Mental Health Services

Acorn Lodge Parents/ Carers’ group meetings every two weeks.

Croydon CAMHS in Partnership with Parents in Partnership held an event at Croydon Carers Centre to develop links and raise awareness of services to parents and carers.

Croydon ADHD Parents Group – 3 day event (2 groups per year) providing information and advice for families following diagnosis.

Croydon Autistic Spectrum Disorders Parents Group – 3 day event (3 groups a year) providing information and advice for families following diagnosis.

Croydon Incredible Years Parenting Skills Group- Programmes run for 10 week.

Croydon Fostering Changes Parent Group.

Lambeth Incredible Years Parenting Skills Group- Programmes run for 12 weeks.

Psychosis

A carers’ liaison volunteer is working with the promoting Recovery teams in Croydon. She is calling clients to update their online (ePJS) information, and sending out leaflets if they wish to know more about support available.
Amardeep service for Asian clients in Lambeth runs an activity afternoon every Wednesday where the first hour of social interaction brings together current or former clients, friends, relatives and carers. Any carers with individual concerns are signposted to help.

The CAG held a successful listening event for mental health carers in partnership with Southwark Carers last December. High on agenda were Social Services changes. The event is being repeated this winter with a focus on care coordination.

**Psychological Medicine and Integrated Care**

Some services have developed specific written information for family & carers e.g.: Clinicians at CADAT developed "Friends and Family" written guides for all the anxiety disorders they treat, or Lewisham A&E Psych Liaison have the carers portfolio which is a resource of support organisations. Some services offer psycho-education or other workshops for family & carers: e.g. Eating Disorders services, OPTIMA (bipolar day programme).

**Acute**

Carers leads on the wards are available to offer information & support.

Lambeth Home Treatment team have developed a resource pack for family & carers.

**Mental Health of Older Adults and Dementia**

Approx. 50 copies of the newly printed Families and Carers Handbook sent to all CAG services – all services make these available to carers.

One ward is developing its own ward Carers Handbook. This will be printed soon. This will be replicated across IP with a bespoke Handbook for each service.

Staff are provided with information from a number of local agencies to use to support their carers and service users.

**Behavioural and Developmental and Addictions**

Quality Improvement work on Chaffinch Ward, Low Secure Unit- welcome letter to carers, telephone survey of carers experiences with the ward, carers room with information, plans for a carers group, links with local carers centre.

Consultants offer a family surgery, where families could come to get some information or support from the team on the ward.

Information leaflet about River House which is sent to families, carers and friends who want to visit their loved one whilst an inpatient.

All 4 Community Forensic and Mental Health Learning Disability teams have the new trust Carers Handbook.

On NAU we have a welcome booklet for parents and carers with relevant information. Additionally we are proposing an extension to the existing model of family engagement by developing a ‘welcome meeting’ that would occur in the first two-three weeks after admission.

New leaflet for service users and carers has been developed which outlines the next steps after an assessment with the Adult ADHD and National Autism Service.

Alcohol Assertive Outreach Team which cover Lambeth and Southwark offer one to one support to carers and families using the 5 Step Method which involves: emotional support, listening to their concerns, involving them in care planning and sign posting to relevant support locally.

3. **Supporting Friends, Families and Carers**
Child and Adolescent Mental Health Services

Mindfulness for Parents and Carers. Lambeth CAMHS Neuro-developmental team delivered a 4 week course with parents and carers on Mindfulness.

Lambeth CAMHS Parents ADHD Group (monthly).

Lambeth Getting Involved’ Parents/Service Users Groups – quarterly meetings open to parents / service users.

Snowsfield Adolescent Unit carers support – every 2 weeks.

Acorn Lodge children’s’ inpatient ward - Monthly carers group.

N&S outpatients - Family and carers support group is a standard component in the Dialectical Behaviour Therapy Service.

Psychosis

Promoting Recovery services run monthly carers’ groups in Southwark, Lewisham and Lambeth. The Southwark group, for example, is led by the carers on what they want discuss on the day. Care co-ordinators, psychologists and others are invited to talk about their roles. Carers also use this space to talk about what is going on for them and are supported by fellow carers. The Lewisham carers’ group has had some recent newcomers and enjoys an average attendance of 12. In Lambeth the carers’ group meets alternately in the evening and the afternoon to widen opportunities for people to attend.

The Complex Care teams across the boroughs run monthly team leader’s surgeries for service users and carers.

Early Intervention Services offer Family Intervention (FI) work and individual carer support sessions. Most run peer support groups for carers. The teams also run regular ‘welcome evenings’ to which all new carers and service users are invited.

Psychological Medicine and Integrated Care

In addition to increasing uptake of the carers engagement & support plan: CADAT is undertaking a research project looking at father’s experiences of partners with perinatal OCD. This will be used to help support partners of people with OCD better. CIPTS ran a small pilot Carer’s Workshop a few months ago; for carer’s of loved ones suffering with PTSD (their loved ones were service users from CIPTS & Croydon Treatment Teams). Touchstone Provide support by phone or face to face when family members are struggling to cope with the patient and are running a QI project in the New Year looking improving support and information to family/carers.

Acute

In terms of promoting the carers engagement & support plan, the Lead OT/ Trust Carers lead has discussed and presented it in the exec meetings. The lead OT has emailed all the ward managers and carers leads asking for “carers” to be a standing agenda item at the ward manager meetings and the ward business meetings. The engagement & support plan will also be discussed at the carers leads event on the 29th November. At service level: · Carers leads are available to offer information & support · Some ward managers hold regular surgeries which carers can attend · Lambeth Home Treatment Team have formalised a pre discharge planning meeting that involves carers to identify what support they would like post discharge from HTT.

Mental Health of Older Adults and Dementia

The CAG delivers a programme of work called If Only I’d Known in all boroughs – sessions last 6 weeks and happen in the day and evening depending on needs of the borough.
Carers and ex carers from SUCAG deliver this project and are supported by the expertise of staff in the CAG. Specific sessions on Assistive technology and legal issues are very welcomed.

A pack of information is provided with details of local and national agencies/activities and support that is available. This is discussed in the group and people ask questions.

Approx. 87 people have been supported by the project since September 2016.

**Behavioural and Developmental and Addictions**

Improvements to Family and Carer visitor suite, brighter decoration, child friendly, information board, sofas.

Improvements for reception area at River House as first place carers/families see – magazines, carers and visitor’s information, water machine, suggestion box, TV screen.

Estia Centre in partnership with service user groups hosted a Service User and Carer Day on 24 May focussed on physical health and wellbeing.

Southwark MHLD team provided a Carers' Day on 14 September to support families and carers of people who behaviour can challenge. Event also focussed on ways for carers to look after themselves and sharing experiences with other carers.

All 4 boroughs: Lambeth, Wandsworth, Bexley and Greenwich have links with their local Carers Centres and staff refer carers.

Carers of people with Addictions invited to the Annual Trust Carers Listening Event.

Adfam in Greenwich support carers/families at the Beresford Project on a weekly basis providing a 6 week programme of education and support.

**4. Developing staff to work with Friends, Families and Carers**

**Child and Adolescent Mental Health Services**

Croydon invited Parents in Partnership to meet with clinicians to talk about what is available and encourage clinicians to sign post parents to Croydon Carers centre.

**Psychosis**

Many teams have dedicated carers’ leads. For example, at the Croydon vocational team (CCOS) the lead attends events and liaises with local neighbourhood carers’ organisations as well as providing individual support.

In the Early Intervention pathway, Behavioural Family Therapy training is run for non-specialist staff so they can offer the approach to the client and his/her social network. Family Intervention is also taught to colleagues, and monthly supervision provided.

Carer support development workers in Lewisham lead workshops on working with carers with information about how to offer a carer’s assessment.

**Psychological Medicine and Integrated Care**

The lead OT is the carers lead for the CAG & attends the Trust-wide Carers Lead meeting.

**Acute**

The lead OT is the carers lead for the CAG & attends the Trust-wide Carers Lead meeting. One of the newly appointed Modern Matrons has a lead role around family & carers.

Wards have carers leads.

The lead OT has arranged a workshop for Carers Leads on 29th November about the role & what it entails.
The lead OT has piloted a training session with ward staff about confidentiality & carers using the recently completed film. She will undertake a further pilot on a Southwark ward.

**Mental Health of Older Adults and Dementia**

Inpatient services have carer’s leads in each service. Some IP services have had training from SUITE in working with and relating to relatives and carers.

Croydon services – CMHT and Memory have started their own Service User and Carer Advisory Group so that staff will work more closely with service users and carers on issues locally in the borough as well as developing ability of staff teams to work more collaboratively/ co-productively with carers and service users.

**Behavioural and Developmental and Addictions**

The social work, psychology and nursing teams work together to respond to needs for various types of family work, ranging from psycho-education to family therapy and couple work. This support is offered in in-patient and community settings. The Forensic Pathway works closely with the Lambeth Couples & Family therapy Service to offer a social integration approach. The Trust prioritises training for staff to undertake Family Therapy training at the Institute of Psychiatry, Psychology & Neurosciences and staff can access supervision support from Trust specialist family therapy supervisors.

Lambeth team is reviewing its monthly carers group at Landor Rd and planning on using the Open Dialogue technique with carers.

Family therapy on the NAU for those families for whom this would be beneficial. Currently we only have one day per week but the CAG is investing in the development of family therapy within the service by supporting me to complete a graduate certificate in family therapy.

PPI Lead & CAG Carers Lead to hold awareness raising sessions with staff on the new Carers Engagement and Support Plan (CESP) over the coming months.

**Service Users in Training and Education (SUITE)**

SUITE has been increasing capacity.

We have just recruited to 2 new posts - SUITE Trainer posts, these are also a development opportunity for those already co-producing training for the Trust as well as an opportunity for local carers in local Trusts, who we hope could bring in new ideas to the Trust. One of these posts will be delivering Carers Training to SLaM staff.

Promotional Campaign to recruit more Carers to SUITE

SUITE is being rebranded so that we have Carers in our name, SUITE leaflet is being updated to reflect this.

SUITE is involved in delivering the Carers session on the HTAS accreditation for Home Treatment Teams Trust-wide for the second year and been asked to continue with this for the foreseeable future.

Continuing to work with teams developing their staff and advertise our course on LEAP.

Training for staff includes: Identifying a Carer / Triangle of Care / Recognising & Acknowledging Carers expertise / Empowering Carers with support & information / Working in partnership with Carers / Carers Assessments

5. **Working in Partnership**

**Child and Adolescent Mental Health Services**
Lewisham CAMHS and Young Minds collaboration. Young Minds ran Parents/carers Peer to Peer training sessions.

Outreach and Training in Schools - The Neuro-developmental Team were invited to present at one of a series of coffee mornings held for parents of children with special educational needs at Michael Tippett School.

Supported Discharge Service and the CAMHS Forensic Psychology service jointly run a Parents Plus Adolescent course for Parents and carers from both service requiring additional support.

**Psychosis**

Croydon Promoting Recovery teams co-produced a successful carers’ open day in autumn 2016 with a carer consultant. Feedback on the day included ‘The videos were a great idea, so realistic and true to life. I liked the ‘tree’ workshop. The food was lovely, thank you. A great treat’; and ‘I know resources are scarce but I feel service users, carers and professionals working together can help each other in making the best of what we have; this takes courage, trust and vision which I saw a glimmer of today which gave me hope, well done.’

The Croydon Family Intervention service employs a carer as a family peer support worker one day a week; the carers’ liaison volunteer in Promoting Recovery is also a carer.

Carers train staff as part of the Early Intervention Behavioural Family Therapy training, sharing their experiences of caring with someone with psychosis. In the Lewisham team carer feedback helped shape the new welcome pack while in the Southwark team a carer spoke about how she looks after her own wellbeing as part of the 2017 world mental health day event.

**Acute**

The Acute CAG is keen to develop strong links with the 4 borough carers forums hosted by the local carers organisations. For the Lewisham meeting, a rota of acute staff members has been developed to attend the monthly meetings, to listen to feedback and to respond to questions. We are hoping to develop the same in the other boroughs.

**Mental Health of Older Adults and Dementia**

Good working links in each borough with AgeUK, Carers Agencies Alzheimer’s Society / Mindcare (Lewisham) as well as some specific groups such as Lewisham Pensioners Forum, FORVIL VCS (Lewisham) Golden Oldies (Southwark) FULA, BME Forum in Croydon, London Wildlife Trust, Certitude (out of hours crisis telephone support) and “Create” an arts workshop project the enables relationships between large multinational agencies and service users/carer groups.

Starting to develop working links with Black Thrive in Lambeth. Good working relationships with Lewisham Healthwatch and emerging working relations with Lambeth Healthwatch in conjunction with Black Thrive.

**Behavioural and Developmental and Addictions**

Team of social workers can refer carers who would like a Carers Assessments in their local boroughs.

PPI lead has visited all 4 teams and informed them of their local carers centre and how they can refer carers to them.

Carers Information provided for all 4 MHLD Teams with links to local carers centres and voluntary sector organisations such as MENCAP.

Lambeth provide one to one support using the 5-Step Method for family & friends of clients of Lorraine Hewitt House (or not yet accessing LHH but resident in Lambeth). This covers: the impact
of the substance use, relevant information, and ways of responding, support networks and on-going support options.

Pier Rd Project in Bexley work in partnership with Bexley Mind to run a regular carers/families support group for people in Bexley caring for someone with an addiction.

Wandsworth have strong links with Wandsworth Carers Centre and refer carers to carers for support to them. Wandsworth Carers have a dedicated worker supporting carers of people with addictions.
REPORT TO THE TRUST BOARD: PUBLIC
28 November 2017

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<tr>
<td>Author</td>
<td>Lucy Stubbings, Head of Patient Safety</td>
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<td>Accountable Director</td>
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Purpose of the paper
Discussion on the Policy for Mortality review, agreement for the process of Board oversight and involvement in the Mortality Review Group.

Executive summary
The paper provides and update on the Mortality Review process and an overview of the findings from Mortality Reviews on deaths reported in quarter 2 of 2017/18. The paper provides an update on the Mortality Review Group, learning with Kings Health Partners and Policy for Mortality Review which is appended for discussion at the Board.

Supporting families and staff affected by deaths is an important aspect of the Trust’s role in providing care. Requirements are outlined as part of the Trust’s statutory Duty of Candour and in the Staff Support Policy.

During quarter 2 100 deaths were reported on the Datix incident reporting system, of these 47 occurred in the Mental Health Older Adults CAG, 79 were natural causes deaths. A range of causes of death are outlined in the paper including cirrhosis, infection (pneumonia). Of the natural causes deaths 3 were linked to inpatient services with each patient’s deterioration being identified and the patient being transferred to an acute Trust for further specialist treatment.

Quality of care identified in the review process is good with the most of the reviews of care provided indicating the although areas of improvement required 7 would require a full Serious Incident Investigation.

Learning is disseminated through Trust Governance processes including the serious incident review group and the mortality review group.

Recommendations to the Board and areas for further development
1. Review of the Trust Mortality Review Group to include Non-Executive Director Membership and Service User and Carer Representation
2. Review of the QI process for identifying and actioning learning within the Mortality Review Group to monitor and maintain work streams and embedding with the Physical healthcare strategy.
3. Quarterly reports to the Trust Board to ensure oversight and action
4. To work with RCPsych to develop guidance on Learning from Deaths and develop our mortality review processes in line with this.
1.0 Introduction
This paper follows on from the September 2017 report to the Board report which outlined the steps taken by the Trust to ensure there are systems in place to review deaths which occur. The report provides an overview of the numbers of deaths reported in Quarter two 2017/18 and the identified learning from these.

2.0 Trust Updates on Learning from Deaths since September 2017

Mortality Review Group
The Trust’s Mortality Review Group is now meeting on a quarterly basis to share learning from themes identified in mortality reviews, receive feedback on serious incident investigations as appropriate and the themes from mortality reviews conducted in CAGS. The next meeting will take place in January and will become part of the Trust physical health committee as the majority of deaths within the Trust are ‘natural causes’ with physical health causes. This will ensure learning identified feeds directly in to the Trust’s physical health strategy and priorities. Attendance will continue from a range of senior clinicians within each of the CAGs.

Sharing Learning from Deaths across Kings Health Partners
The Trust is part of the Kings Health Partners Safety Connections Network, on 10 October Dr Daniel Harwood, Clinical Director of Mental Health Older Adults CAG represented the Trust at the Network evening event discussing the key areas of learning the CAG and Trust have identified since starting the formal Mortality Review process. The emphasis of Dr Harwood’s presentation was the additional learning and changes in CAG practice and priorities; examples of this included the outstanding practice of a number of clinicians and the need to get the basics of good quality care right

The event gave the opportunity for SLaM to share learning with Kings College Hospital and Guys and St Thomas’ and to hear how their processes are embedding. Feedback on SLaM’s contribution was extremely positive as the Trust provided a balanced review of the challenges of implementing mortality review e.g time commitment and the benefits.

Mortality Review Policy
Towards the end of September 2017 the Trust’s Policy for Mortality Review was ratified and published on the Trust’s internal and external website.

3.0 Being Open and Duty of Candour
It is expected that timely and sensitive contact is made with families, carers and relevant people affected by the deaths of patients in contact with Trust services. Requirements are outlined as part of the Trust’s statutory Duty of Candour and in the Being Open and Duty of Candour Policy.

Bereaved families should be provided with support from the time of the death and following with notification of any findings from the Mortality Review process. This area is something that is being focussed on within Q3 and Q4 as there is a need to improve staff awareness of the principles of Duty of Candour and how to effectively implement this. Where the Trust’s care has resulted in harm a serious incident investigation should take place which answers any concerns raised by families and is shared when concluded.

4.0 Staff Support
The Trust recognises that deaths can be difficult for staff as well as families. There is a policy for supporting staff which is currently under review with focus groups taking place to meet with clinicians affected by serious incidents including deaths. The Critical Incident Staff Support programme provides facilitated support sessions to teams who need additional support. In addition to line management support all staff have access to the Trust counselling services.

5.0 Number of reported deaths in Quarter 2
The Trust receives notifications of patient deaths from a range of sources including the Police, families, and the Office of National Statistics feed through the CRIS team.

1 https://www.slam.nhs.uk/media/477582/mortality_review_policy.pdf
Table 1 Reported deaths in Q2

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<td>Probable Suicide</td>
<td>2</td>
</tr>
<tr>
<td>Addictions</td>
<td>Death Due To Accidental Overdose</td>
<td>1</td>
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<tr>
<td></td>
<td>Natural Causes</td>
<td>6</td>
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<tr>
<td></td>
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<td>1</td>
</tr>
<tr>
<td></td>
<td>Alleged Murder OF Patient</td>
<td>1</td>
</tr>
<tr>
<td></td>
<td>Natural Causes</td>
<td>3</td>
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<tr>
<td></td>
<td>Probable Suicide</td>
<td>1</td>
</tr>
<tr>
<td>Behavioural &amp; Developmental Psychiatry</td>
<td>Death As A Result Of A Road Traffic Accident</td>
<td>1</td>
</tr>
<tr>
<td></td>
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<td>2</td>
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<tr>
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<td>1</td>
</tr>
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<td>1</td>
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<td></td>
<td>Natural Causes</td>
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<td>Psychological Medicine &amp; Integrated Care</td>
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<td>1</td>
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<td></td>
<td>Probable Suicide</td>
<td>2</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td></td>
<td><strong>100</strong></td>
</tr>
</tbody>
</table>

During quarter 2017/18 100 deaths were reported on the Datix incident reporting database. As expected the highest number of these occurred in the MHOA and Dementia (MHOA&D) CAG with 47% of these. The highest category given to the death was natural causes, 79% followed by probable suicide 16% with the highest number occurring in Psychological Medicine and Integrated care 16. The teams which experienced the highest number of suicides were PMIC Assessment and Liaison Teams.

4 deaths were reported linked to inpatient units 3 of these were natural causes deaths which occurred in acute hospitals: 1 expected death of a patient with terminal cancer; 1 patient with deteriorating physical health led to transfer and 1 death following a fall on an inpatient ward which is currently being investigated. The remaining death was a suspected suicide of a patient not on the ward which is being investigated as a comprehensive investigation.
Of the natural causes deaths 65% did not have a clear cause of death at the time of reporting as recorded in the incident sub-category. 2 of the 4 deaths reported under Liver Failure/Cirrhosis occurred in the Addictions CAG with the remaining 2 occurring in psychosis.

The death reported as a Deep Vein Thrombosis was a patient who was being treated by the PMIC Assessment an liaison team.

All 4 deaths categorised under infection were reported in MHOA&D with 3 of the 4 cases of incidents of pneumonia (1 case acquired in a general hospital). The remaining case was linked to cellulitis of a patient who had been in an acute hospital for a number of months.

**Figure 1 Sub category of reported deaths**

### 4.0 Learning from Mortality Reviews in Q2

Mortality Reviews should be completed for all patients who are open to Trust services or within 1 month of discharge at the time of their death. Between 2 and 6 months post discharge contact should be made with a patient’s GP to ascertain if there are any concerns about the care that the Trust has provided. If any concerns are highlighted then the Mortality Review process should commence. The exception to this is for any deaths of a patient with a Learning Disability where a review will take place for all patients who are open to Trust services or within 12 months of discharge.

The process of mortality review follows the diagram below with an initial review completed using version of the Mazar framework and where indicated a further review using an adapted version of the National Confidential Enquiry into Patient Outcome and Death (NCEPOD) coding.

59 of the deaths reported in Q2 underwent the part of all of the Mortality Review process. 50 deaths underwent coding using the Mazar criteria, 12 were coded as Expected Natural 1 – no further action is required.

**Table 2 Mazar coding for reported deaths**

<table>
<thead>
<tr>
<th>Mazar Framework Criteria</th>
<th>Number</th>
</tr>
</thead>
<tbody>
<tr>
<td>EN1 - Expected Natural (EN1): Death was expected to occur within an expected timeframe. E.g. people with terminal illness. These deaths are unlikely to be preventable.</td>
<td>12</td>
</tr>
<tr>
<td>EN2 - Death was expected but were not expected to happen in the timeframe.</td>
<td>14</td>
</tr>
</tbody>
</table>
E.g. someone with cancer or liver cirrhosis who dies earlier than anticipated.

Table 3 NCEPOD coding for reported deaths

<table>
<thead>
<tr>
<th>NCEPOD Grading</th>
<th>Number</th>
</tr>
</thead>
<tbody>
<tr>
<td>A - A standard that you accept for yourself, your trainees and your institution</td>
<td>12</td>
</tr>
<tr>
<td>B - Aspects of clinical care could have been better</td>
<td>22</td>
</tr>
<tr>
<td>C - Aspects of organisational care could have been better</td>
<td>5</td>
</tr>
<tr>
<td>D - Aspects of both clinical and organisational care could have been better</td>
<td>1</td>
</tr>
<tr>
<td>E - Several aspects of clinical and/or organisational care that were well below satisfactory. Requires reporting as Serious Incident</td>
<td>1</td>
</tr>
<tr>
<td>F - SI investigation initiated, unable establish at time of Mortality Review</td>
<td>6</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>47</strong></td>
</tr>
</tbody>
</table>

9 deaths underwent part two of the mortality review without being graded according to the MAZAR framework, details of all deaths graded under the criteria are shown below.

The initial review data indicates that overall the quality of care as found in the mortality review process is good with some areas of improvement. Of the reported incidents 7 were indicated to require a full serious incident investigation. Of these one had already had a serious incident investigation commissioned.

When looking at this in the context of other reviews relating to deaths within the quarter 12 further reviews were commissioned 9 were notified to commissioners in line with the Serious Incident Framework with the remaining 4 under Safeguarding Review processes. Mortality Reviews will lead to additional reviews of deaths that would not have normally met the threshold for investigation by the Trust.

Learning identified in this quarter include the updating of risk assessments to allow the risk information to be shared. Communication with Primary Care both in relation to risks and the management of physical health needs, clarification of plans roles and responsibilities.

5.0 Dissemination of learning across the Trust and to the Board

Each CAG should have a monthly forum to hold oversight of mortality reviews within the CAG, areas of learning can be discussed agreed and any plans to change practice, policy or procedures agreed. The CAG governance execs can escalate as required via the Quality Sub Committee to the Trust Board or to the Trust’s Mortality Review Group.

The Trust’s Serious Incident Review Group (SIRG) reviews serious incidents which are notified to commissioners, as part of the sources of information used within the Mortality Review process it is expected that Serious Incident investigations use this as the a source of information. The SIRG will discuss and agree learning points that should be shared across the Trust and the forums to do so.

As reviews are completed and further investigations progress the tracking of learning will be completed using the Datix system, currently in use for complaints, incidents, PALS and risks amongst other areas. This will allow more comprehensive triangulation of the learning and dissemination across pathways.

The Mortality Review Group not only monitors the completion and learning from Mortality Reviews but will look at the overall trust themes. The Trust’s Medical Director will escalate any immediate actions to CAG Clinical Directors and the Trust Board as required. The Quality Improvement team are part of the core
membership of the group and support clinicians to take forward identified learning. The Mortality Review Group will discuss and agree any learning points that should be shared across the Trust and the forums to do so.

The Trust’s Learning from Deaths reports are published internally and circulated via the CAG Governance Committees to note and review any actions. This improves transparency in the process and will support staff to understand the process and outcomes.

The Trust Board will receive quarterly updates on Learning from Deaths. As part of the Quality Sub Committee this information will be viewed in the context of other quality indicators across the Trust. The information reported to the Trust will be published as part of the Quality Account.

6.0 Recommendations to the Board and areas for further development

1. Review of the Trust Mortality Review Group to include Non-Executive Director Membership and Service User and Carer Representation
2. Review of the QI process for identifying and actioning learning within the Mortality Review Group to monitor and maintain work streams and embedding with the Physical healthcare strategy.
3. Quarterly reports to the Trust Board to ensure oversight and action
4. To work with RCPsych to develop guidance on Learning from Deaths and develop our mortality review processes in line with this.
Appendix 1

Note from Anna Walker following attendance at NHSI event on Learning from Deaths.

NHSI networking event for NEDs: 19 October 2017

1. I attended this event on 19/10. The NHSI lead was Steve Russell, NHSI Executive Managing Regional Director for London. The first half concentrated on NHSI’s priorities for the NHS this winter (first priority safety of patients through the winter (coping with the upsurge!), and the recovery of cancer targets and living within available resources. Dr Andy Whitfield, Clinical Chair for North East Hampshire and Farnham CCG then spoke about their partnership with others in Surrey as an Accountable Care System to improve patient pathways by working differently across traditional service boundaries. This included a crisis café aimed at treating mental health patients without them having to go to a and e. He also said they had GPs working on discharges within the hospital, patients codesigning new services with clinicians and the hospital becoming a social care provider in the community. The latter initiative is designed to prevent bed blocking and Dr Whitfield said that Frimley Park’s “brand name” meant they found it easier to recruit care workers than other organisations. They were clearly very pleased by the significant halt in hospital utilisation as a result of these initiatives.

2. Kathy McLean, the NHSI Medical Director, then spoke about the NHSI’s approach to learning from deaths as a result of the CQC’s December 2016 report “Learning, candour and accountability: a review of the way NHS Trusts review and investigate the deaths of patients”. Kathy spoke to slides. I have emailed her and Steve Russell to ask for copies of these but have had no response.

3. Kathy said that one of the key issues that had emerged from the CQC report was that there was no consistency in the way NHS trusts investigated deaths. Guidance had therefore been brought out in the Learning From Deaths framework and NHSI attached considerable importance to Board action on, and involvement in, this issue (it emerged later through questioning that the guidance is primarily for acute trusts at the moment. I understood that the intention was to develop future guidance specifically for mental health and learning disabilities deaths but, in the meantime, NHSI consider the principles of the guidance apply to all trusts).

4. Kathy said the main principles in the Learning from Deaths framework were:-
   - Increased transparency about deaths that had occurred
   - Candour around what had caused the deaths
   - The involvement of families and carers in the reasons for deaths and any subsequent investigation
   - Visible continuous learning and development in trusts as a result of understanding the causes of deaths
   - Strong leadership from the top of the organisation- both executive and non executive – in acting on these principles.

5. Kathy outlined the following timetable for action:-
   - From April 2017 trusts were required to pull together quarterly information on deaths, reviews, investigations and the resulting quality improvements
   - From Q3 2017/8 (December), trusts must publish the information required in the first bullet point in Board papers which are publicly available
   - The 2017/8 Quality Accounts will require annual disclosure of the above information
6. Kathy then said NHSI saw the **NED role** as follows:-

- **A critical leadership role** in embedding learning from deaths in the organisation
- Responsibility to ensure **the trust really was acting on the learning** emerging from the reviews and investigations and improvements were occurring
- A key role in **holding the organisation to account** for learning from deaths

She stressed the importance of regular Board discussions on these issues

7. There was then a question and answer session. The main messages from this were:-

- Investigations take real skill. NHSI is looking at the possibility of developing an accreditation process for this
- It was up to trusts to decide what percentage of deaths to investigate over and above those which were statutorily required. This would inevitably be dependent on the availability of resources. The important thing was for a trust to be clear why it was doing whatever it decided to do and make its policy public
- NHSI was still aiming for the introduction of "medical examiners" (independents on investigation teams as I understand it) by April 2019
# POLICY FOR MORTALITY REVIEW

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<th>1</th>
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<tbody>
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<td>Ratified By:</td>
<td>Clinical Policy Working Group</td>
</tr>
<tr>
<td>Date Ratified:</td>
<td>26th September 2017</td>
</tr>
<tr>
<td>Date Policy Comes Into Effect:</td>
<td>26th September 2017</td>
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| Author: | Lucy Stubbings, Head of Patient Safety  
Mary O’Donovan, Head of Quality & |
| Responsible Director: | Dr Michael Holland, Medical Director |
| Responsible Committee: | Mortality Review Group |
| Responsible Committee Approval Date: | 20th July 2017 |
| Target Audience: | Clinical Staff |
| Review Date: | October 2018 |

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<th>Assessor: Lucy Stubbings</th>
<th>Date: 31/08/2017</th>
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<td>HRA Impact Assessment</td>
<td>Assessor: Lucy Stubbings</td>
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**Mortality Review Policy v1, September 2017**
### Document History

#### Version Control

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<th>Date</th>
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<td>1.0</td>
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<td>New Policy</td>
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#### Consultation

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<td>Mortality Review Group</td>
<td>15/06/17</td>
<td>Clarification of internal and Trust processes including roles and responsibilities</td>
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<tr>
<td>Clinical Directors, Governance Teams, Legal Services and QI</td>
<td>16/08/2017</td>
<td>Updates to wording and links to other policies made</td>
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#### Plan for Dissemination of Policy

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<td>Trust intranet</td>
<td>Electronic</td>
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**Key changes to policy:**

N/A – this is a new policy

#### Plan for Implementation of Policy

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<td>CAG Clinical Directors will ensure policy implementation within monthly MRG forums, with oversight from the Trust MRG who will monitor implementation and efficacy of the policy through its quarterly meetings.</td>
<td>Medical Director/ CAG Clinical Directors</td>
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1 Introduction

This policy outlines the procedures and guidance around mortality governance in support of both the Trust’s local Incident Policy and Investigation Policy. This policy should also be read in conjunction with the NHS England Serious Incident Framework (2015) and the National Quality Board National Guidance on Learning from Deaths (March 2017).

2 Background

This policy is produced in the context of national concerns regarding mortality rates, and the reporting and investigation of tragic deaths of patients in the care of NHS services.

The purpose of Mortality Review is to establish whether aspect of care provision may have contributed to the death of our patients, in order to learn from these to prevent recurrence. This learning will be used to improve the way the Trust’s services are delivered as well as working with partner organisations to reduce avoidable or premature death.

3 Definitions

3.1 Patient
The term ‘patient’ will be used to describe all patients and services users who are currently or have previously been under the care of the Trust.

3.2 Incident
An event or circumstance which could have resulted, or did result, in damage, loss or harm to patients, staff, visitors or members of the public.

3.3 Mortality Review
A process undertaken after the death of a patient who was in receipt of SLaM services or after discharge from services which aims to identify, understand and learn from any problems identified with the quality of care delivered.

3.4 Datix
Datix is the electronic database used within SLaM to help monitor and evaluate issues which impact on the safety of patients, healthcare workers, visitors and contractors. Incidents, complaints, concerns, risks and claims/inquests are reported on the system enabling robust management whilst contributing to the safety culture and learning of the entire Trust.

3.5 Clinical Records/Notes
SLaM services use a number of ‘clinical notes’ systems e.g. ePJS and IAPTUS. The terms clinical notes will refer to all electronic patient record systems are used within SLaM to document all patient interactions and care provided.

4 Purpose and Scope

This policy will provide guidance to staff on which deaths should be reported on Datix, outline the process of Mortality Review and the Trust’s governance structures to support the Mortality Review Process. The policy should be read in conjunction with the Incident Policy, Policy of Investigation of Incidents, Complaints and Claims, Policy for Supporting Staff involved in incidents, complaints or claims, Being Open and Duty of Candour Policy

5 Roles and Responsibilities

5.1 All Trust Staff
All Trust staff have a responsibility to ensure patient deaths are recorded in the clinical notes and reported on Datix. Although it is preferable that reporting is completed by a
member of the patient’s clinical team, any member of staff informed of the death can report. The incident policy states that this should be the most senior person on duty. Further information can be found in the incident policy.

5.2 Trust Medical Director
The Trust Medical Director is the executive lead for Mortality Review and is responsible for ensuring the systems within the Trust are fit to provide a review of mortality and learning from the findings of Mortality Reviews is embedded and disseminated.

5.3 CAG Clinical Directors
The Clinical Academic Group (CAG) clinical directors and responsible for ensuring their CAG has an appropriate system for the review of reported deaths by a senior doctor. The Clinical Director is responsible for ensuring CAG medical and nursing attendance at the Trust’s Mortality Review Group (MRG) and timely reports are submitted to the MRG.

5.4 Non-Executive Directors
The Board of Directors are collectively responsible for ensuring the quality and safety of healthcare services provided by the Trust. The Mortality Review group and policy will be overseen by the Quality Sub Committee which is chaired and attended by Non-Executive Directors, thereby providing assurance that the processes in place are robust.

5.5 Mortality Review Group (MRG)
The MRG is responsible for monitoring the number of patient deaths and themes arising from Mortality Reviews across the Trust. The MRG is chaired by the Medical Director with oversight by the Trust Board and attendance from each of the CAGs. The terms of reference are found in Appendix 1.

5.6 Learning Disability Mortality Review Programme (LeDeR) lead for Mortality
The Learning Disability Mortality Review Programme (LeDeR) lead for Mortality is the Behaviour and Developmental Psychiatry Clinical Director for Neurodevelopmental Services.

6 Bereaved Family and Carers

When a patient in receipt of care from the Trust dies, within an inpatient setting, bereaved families and carers should be informed immediately. In all circumstances of a death, contact should be made to offer support to the family in a clear, honest and compassionate way.

Bereaved families and carers have a right to raise concerns about the quality of care and thereby help to inform decisions about whether a review or investigation needed. Bereaved families and carers are partners in an investigation and should receive a timely, responsive contact in all aspects of the investigation process.

Duty of Candour should always be followed when a patient dies, as it is unclear if any aspects of care provided may have led to the harm of the patient. Further information can be found in the Trust’s Being Open and Duty of Candour Policy.

A condolence letter should be sent to bereaved family and carers to
• Offer support and condolences for the death of the patient
• Inform them of the Mortality Review and any other investigative processes
• Invite them to contribute their views on the patient’s care
• Provide details of a named contact who can be a resource for them during the review process investigation process or who can be contacted at a later stage
• Signpost them to organisations who can provide them with further support
7 Process for reporting deaths

All deaths of patients who currently receive care from SLaM services, including where the patient is in receipt of palliative care and instances of expected death are reportable. Additionally deaths of patients up to 6 months post discharge are reportable (with the exception of those with Learning Disability, see below). The level of review will be defined following the initial review and completion of the Mortality Review form (See Appendix 2).

In instances where a patient with has an apparent or secondary diagnosis Learning Disability has accessed any SLaM service all deaths should be reported within 12 months of their last contact. The Trust has a Learning Disability Mortality Review Programme (LeDeR) lead for Mortality. See National guidance flow chart (Appendix 3).

Deaths which must be reported on Datix within the Trust and will require the completion of a Mortality Review Form are outlined below in Table 1.

<table>
<thead>
<tr>
<th>Diagnosis of Learning Disability</th>
<th>Deaths which must be reported on Datix by CAG</th>
<th>Mortality Review</th>
</tr>
</thead>
<tbody>
<tr>
<td>All CAGs</td>
<td>All patients who are open to a service or were discharged in the 6 months preceding their death</td>
<td>Open to service or within 1 month of discharge Complete Mortality Review - 2- 6 months post discharge Admin to contact GP to ascertain any concerns about care provided</td>
</tr>
<tr>
<td>Diagnosis of Learning Disability</td>
<td>All patients who are open to a service or were discharged in the 12 months preceding their death</td>
<td>Full Mortality Review section 1 and section 2</td>
</tr>
</tbody>
</table>

Table 1: Trust criteria for reporting deaths and mortality review

8 Mortality Review Form (Appendix 2)

The current version of the Mortality Review Form (MRF) will always be held within the Datix incident record. The version within appendix 2 is the version at the time of ratification of the policy.

The Trust adapted two frameworks to use for Mortality Review. Permission was given to use the Mazar framework\(^1\) used to review deaths within Southern Health. The criteria has been developed to be applicable to mental health patients. The National Confidential Enquiry into Patient Outcome and Death (NCEPOD) grading system for case reviewers\(^2\) has been adapted for use within part 2 of the form.

Each death reported on Datix which meets the criteria outlined in Table 1 will require the Mortality Review Form (MRF) to be completed. The MRF is completed by a senior doctor from outside of the immediate team, it is split into two sections; section 1 provides an initial review of the death and further information is collated in section 2. The MRF can be viewed on the Datix record, merged into a Word document or exported into a report.

The purpose of Mortality Review is to identify
- Provide an immediate assessment of the reason for the death
- Identify any concerns about the care provided which may have contributed to the death

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2. [http://www.ncepod.org.uk/grading.html](http://www.ncepod.org.uk/grading.html)
- Examine involvement from external agencies and any factors related to these
- Determine if further investigation is required

8.1 MRF Section 1
Section 1 of the MRF should be completed electronically by a senior doctor within 3 working days (dependent on service operating hours) of notification of the death on Datix. The section provides an overview of information and uses Mazar criteria outlined in Appendix 2. If the death is assessed to fall into the category of an Expected Natural (EN1) death, no further Mortality Review is required however section 2 can be completed where the CAG identify a potential for learning and improvement in care. If the death is assessed to fall into any other category then the MRF section 2 must be completed.

8.1.1 Cause of death
A patient’s cause of death is detailed on their death certificate and can be requested through legal services or directly from the Coroner. This may not be available within the 3 working days to complete part 1. Further attempts should be made to request the cause of death following the completion of part 1, the Mortality Review Form can then be reviewed once received. An assessment using the Mazar criteria should be made based on the available information at the time.

8.2 MRF Section 2
Section 2 of the MRF should be completed within 7 working days of the notification of the death on Datix. The section uses the NCEPOD classification of care criteria to indicate whether further investigation is required. Section 2 of the Mortality review form should be completed if meets requirements of Mazar criteria.

![Diagram](image)

**Figure 1 Overview of process of Mortality Review**

9 Fact Finding Report
The fact finding report is a concurrent initial incident review where more information or brief investigation is required. All incidents notified to service commissioners require a fact finding report. Fact finding reports should be completed within two working days (dependent on service operating hours) and are inputted electronically onto the Datix record. Further information can be found in the Incident Policy and Policy for the Investigation of Incidents, Complaints and Claims.
10 Training

Training is available on the use of Datix and structured investigations through the Education and Development Department, accessed using the Trust training portal LEAP.

11 Support for Staff

The Trust takes its duty of care to protect the physical and mental wellbeing of its staff seriously and is committed to providing appropriate support to staff involved in traumatic/stressful incidents based on their needs. It is the line manager’s responsibility to discuss the support required by an individual, signposting or referring them to support services and refer them as appropriate to minimise the harmful effects of these events.

The Critical Incident Staff Support Service (CISS) aims to provide support to staff who have been involved in a significantly distressing incident at work. The CISS service runs alongside existing staff support services and provide teams with the opportunity to discuss the events. Further information can be found in the Trust Policy on Staff Supporting Staff Policy.

12 Governance and Assurance

12.1 Trust wide Mortality Review Group

In 2016, the Mortality Review Group (MRG) in SLaM was moved to a central group from individual CAG processes. This change was implemented following advice from NHS England to improve individual Trust's self-assessment of mortality and to ensure that learning was embedded. Further detail can be found in the terms of reference, appendix 1.

The MRG is held quarterly and is a sub-group of the Trust Board chaired by the Medical Director. Attendance at the group is expected from all the CAGs within the Trust. Each CAG should have a mortality lead and ensure that their processes align to feed into the MRG.

12.2 Local Mortality Review Processes

CAGs will facilitate local Mortality Review processes/ forums on a monthly basis which will review Mortality Review Forms and to ensure a consistent approach to Reviews. Data and themes from deaths will be reviewed and forwarded to the Trust wide Mortality review Group on a quarterly basis, along with details of any shared learning or matters identified for further review on a Trust wide basis.
Death Reporting Process

Service informed of death of a patient
(notification criteria see table 1)

Record death in clinical record
Report death on Datix system

Complete Section 1 of Mortality Review Form
72 hours or 3 working days

Feedback to members of staff and other teams involved of learning from the death

Themes, trends and learning taking to Mortality Review Group for Review (must be held a minimum of quarterly)
13 Monitoring Compliance

<table>
<thead>
<tr>
<th>What will be monitored i.e. measurable policy objective</th>
<th>Method of Monitoring</th>
<th>Monitoring frequency</th>
<th>Position responsible for performing the monitoring/performing co-ordinating</th>
<th>Group(s)/committee(s) monitoring is reported to, including responsibility for action plans and changes in practice as a result</th>
</tr>
</thead>
<tbody>
<tr>
<td>Policy Compliance</td>
<td>Audit</td>
<td>Annual</td>
<td>Audit Team</td>
<td>Mortality Review Group</td>
</tr>
</tbody>
</table>

14 Associated Documentation

- Incident Policy, (SLaM)
- Policy for the Investigation of Incidents, Complaints and Claims, (SLaM)
- Being Open and Duty of Candour Policy, (SLaM)
- Policy for Supporting Staff Involved in Incidents, Complaints or Claims, (SLaM)
- Safeguarding Adults Policy
- Safeguarding Children Policy

15 References


Appendix 1. Terms of Reference for Mortality Review Group

South London and Maudsley NHS Foundation Trust

Terms of Reference for Mortality Review Group (MRG)

December 2016 (V3.1)

To be revised July 2017 or sooner if appropriate

Overall aim or purpose

To establish the cause of death of our patients and if there is anything we can do in the way we deliver our services or work with partners to improve avoidable or premature death.

- To act as the strategic Trust mortality overview group with senior leadership and support to ensure the alignment of the services across the Trust for the purpose of reducing all avoidable deaths.
- Learning from death is a key purpose of this group and commissioning thematic reviews arising from the various reports or issues highlighted by the data.
- Strategic oversight of Mortality Review committee(s) both local and Trust wide.
- To produce a Mortality Reduction Strategy that aligns Trust systems such as audit, information services, training and clinical directorates. This strategy will be reviewed on an annual basis by the Medical Director.
- Sign off of action plans and methodologies that are designed to reduce morbidity and mortality across the trust.
- Sign off of all regulatory mortality responses.
- To report on Mortality performance to the Board.

Operational functions

- To work towards the elimination of all avoidable mortality.
- To review on a monthly basis, available benchmarked mortality rates of the Trust.
- To consider the mortality data in conjunction with other qualitative clinical data as well as national benchmarking data available and identify areas for future investigation.
- To investigate any alerts received from the Care Quality Commission (CQC) or identified by the Mortality monitoring information systems e.g. Dr Foster, HED, etc.
- To develop data collection systems to ensure the Trust's mortality data is timely robust and in line with national and international best practice.
- To ensure mortality information linked to consultant appraisals is accurate, contextual and engenders a culture of clinical excellence.
- To develop an annual mortality clinical coding improvement plan and receive regular reports on its implementation.
- To assign clinical leads to address raised mortality in particular clinical areas by the deployment of strong evidence based interventions such as care bundles. The MC will receive regular reports on implementation and the measurable impact of these interventions on patient mortality. This will include work streams such as suicide prevention and Homicide reviews.
- Working with CAGs to establish how clinicians receive the latest guidelines on care protocol implementation and clinical coding best practice.
- To review and monitor compliance with other Trust policies including DNAR and Death Certification Policy.
- To monitor and consider the information from the electronic review of all in Trust deaths.

**Accountability:** The MRG is formally accountable the Trust Board

<table>
<thead>
<tr>
<th>Membership:</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Chair – Medical Director</strong></td>
</tr>
<tr>
<td>Director of Nursing or Deputy</td>
</tr>
<tr>
<td>Doctor – medical representative from each CAG</td>
</tr>
<tr>
<td>Patient Safety Team representative</td>
</tr>
<tr>
<td>Trust Carers Lead</td>
</tr>
<tr>
<td>Academic representation- IOP</td>
</tr>
</tbody>
</table>

**Quorum:**

Four members plus the Chair (one nurse, two doctors and a governance representative).

**Frequency of meetings:**

The Committee will meet Quarterly – frequency will need review.

**Workplan for 2016/2017**

- To establish Mortality Review process
- To establish a mortality reduction strategy
- To establish data collection systems for all mortality
- Establish Clinical work streams with a Clinical lead
- Assign mortality data to Consultant’s appraisal
- Processes for Team review
Appendix 2. Mortality Review Form – *the current version will always be on the Datix record*

### Mortality Review Form v8

#### Section 1

| Datix Reference |  |
| Forename |  |
| Surname |  |
| Trust I.D |  |
| Date of Admission to SLaM services |  |
| Date Of Discharge From SLaM Services |  |
| *1 month post discharge*  
( check with primary services ie.GP, if any area of concern requiring further review complete Sec 2) |  |
| Date of Death |  |
| Time of Death |  |
| Consultant at time of death |  |
| Did the patient have a diagnosis of learning disability? |  |
| In-patient/Community ward/team | CAG: |
| | Pathway: |
| | Service: |
| Location of death |  |
| Category |  |
| Diagnosis |  |
| Cause of death |  |

#### MAZAR Criteria

<table>
<thead>
<tr>
<th>MAZAR Criteria</th>
<th>Description</th>
<th>Action</th>
</tr>
</thead>
<tbody>
<tr>
<td>EN</td>
<td>Expected Natural (EN1): Death was expected to occur within an expected timeframe. E.g. people with terminal illness. These deaths are unlikely to be preventable.</td>
<td>No further action</td>
</tr>
<tr>
<td>EN2</td>
<td>Death was expected but were not expected to happen in the timeframe. E.g. someone with cancer or liver cirrhosis who dies earlier than anticipated.</td>
<td>Complete Section 2</td>
</tr>
<tr>
<td>EU</td>
<td>Death was expected but not from the cause expected or timescale. E.g. those relating to substance misuse or eating disorder.</td>
<td>Complete Section 2</td>
</tr>
<tr>
<td>UN1</td>
<td>Unexpected death which are from a natural cause e.g. sudden cardiac condition or stroke.</td>
<td>Complete Section 2</td>
</tr>
<tr>
<td>UN2</td>
<td>Unexpected death from a natural cause but which didn’t need to be e.g. some alcohol dependency and where there may been care concerns.</td>
<td>Complete Section 2</td>
</tr>
<tr>
<td>UU</td>
<td>Unexpected deaths which are from unnatural causes e.g. suicide, homicide, abuse or neglect.</td>
<td>Complete Section 2</td>
</tr>
</tbody>
</table>
To be completed if death was not rated as EN1

<table>
<thead>
<tr>
<th>Section 2 – completed if death is NOT graded as EN1</th>
</tr>
</thead>
<tbody>
<tr>
<td>Highlight significant co-existing factors/PMH/comorbidity</td>
</tr>
<tr>
<td>Additional information</td>
</tr>
<tr>
<td>Were Any Other Partner Organisations Involved? (E.g. Housing, General Hospital)</td>
</tr>
<tr>
<td>Additional information</td>
</tr>
<tr>
<td>Was the care plan appropriate?</td>
</tr>
<tr>
<td>Additional information</td>
</tr>
<tr>
<td>Was the care plan followed?</td>
</tr>
<tr>
<td>Additional information</td>
</tr>
<tr>
<td>Was there clear monitoring of the care plan (e.g. observations, reviews)</td>
</tr>
<tr>
<td>Additional information</td>
</tr>
<tr>
<td>Is there evidence in Events that the care plan was followed?</td>
</tr>
<tr>
<td>Additional information</td>
</tr>
<tr>
<td>Is the Risk Assessment up to date and relevant?</td>
</tr>
<tr>
<td>Additional information</td>
</tr>
<tr>
<td>Have physical health investigations been reviewed?</td>
</tr>
<tr>
<td>Additional information</td>
</tr>
<tr>
<td>Were there any prescribing errors?</td>
</tr>
<tr>
<td>Additional information</td>
</tr>
<tr>
<td>Was there a DNR decision?</td>
</tr>
<tr>
<td>Additional information</td>
</tr>
<tr>
<td>Was an advance decision documented?</td>
</tr>
<tr>
<td>Additional information</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>NCEPOD Classification of Care grade</th>
</tr>
</thead>
<tbody>
<tr>
<td>NCEPOD Classification Of Care Grade – Additional Information</td>
</tr>
<tr>
<td>Senior Doctor Completing Review</td>
</tr>
<tr>
<td>Date of Completed Review</td>
</tr>
<tr>
<td></td>
</tr>
<tr>
<td>---</td>
</tr>
<tr>
<td>A</td>
</tr>
<tr>
<td>B</td>
</tr>
<tr>
<td>C</td>
</tr>
<tr>
<td>D</td>
</tr>
<tr>
<td>E</td>
</tr>
<tr>
<td>F</td>
</tr>
</tbody>
</table>

- **A** Good Quality: A standard that you accept for yourself, your trainees and your institution
- **B** Room for improvement: Aspects of clinical care could have been better
- **C** Room for improvement: Aspects of organisational care could have been better
- **D** Room for improvement: Aspects of both clinical and organisational care could have been better
- **E** Less than satisfactory: Several aspects of clinical and/or organisational care that were well below satisfactory. Requires reporting as Serious Incident
- **F** Other: SI investigation initiated, unable establish at time of MR
Appendix 3. LeDeR Process Flowchart

LeDeR Process Flowchart

Notifications
LeDeR Team receive notification. Identify those meeting criteria for review.

Inform and assign cases for review
LeDeR Team informs Local Area Contact of a new case.
LAC identifies suitable reviewers and informs LeDeR.
LeDeR Team informs reviewer of the case allocation.

Local reviewer: pre-initial review information gathering
Is this individual subject to any other existing review process?

Yes

Initial Review
Conversation with someone who knew the person well.
Review of relevant case notes.
Complete pen portrait, timeline and action plan.

No

Further Action
Prepate for Multi-agency Review
Contact other agencies involved.
Contact family members/someone who knew person well.
Request relevant notes and documents.
Arrange and prepare for multi-agency meeting.
Update case documentation.

Decide whether further action is required
Further action is required:
Additional learning could come from a fuller review;
If it is a Priority Themed Review;
If red flags indicate this.

No Further Action
The completed report and action plan is returned to the Local Area Contact for sign off and then sent to the LeDeR Programme.

Link in with other process
Establish the nominated contact for the other review process and liaise with them.
Where possible collect core data required for the LeDeR review. Provide learning disabilities expertise to other review process if appropriate and required.

Agree with the other review process
Complete initial review.
Agree comprehensive pen portrait and timeline.
Agree potentially avoidable contributory factors.
Identify lessons learned.
Agree on good practice and any recommendations.

Multi-agency Meeting
Agree comprehensive pen portrait and timeline.
Agree potentially avoidable contributory factors.
Identity lessons learned.
Agree on good practice and any recommendations.
Complete action plan.

Share with Steering Group
Local Area Contact shares anonymised learning points and actions with their relevant Steering Group to ensure learning is embedded and action plans are taken forward.

Summary and Close
The completed report and action plan is returned to the Local Area Contact for sign off and then sent to the LeDeR Programme.

V2.2 Jan 2017
Appendix 4. Equality Impact Assessment

PART 1: Equality relevance checklist

The following questions can help you to determine whether the policy, function or service development is relevant to equality, discrimination or good relations:

- Does it affect service users, employees or the wider community? Note: relevance depends not just on the number of those affected but on the significance of the impact on them.
- Is it likely to affect people with any of the protected characteristics (see below) differently?
- Is it a major change significantly affecting how functions are delivered?
- Will it have a significant impact on how the organisation operates in terms of equality, discrimination or good relations?
- Does it relate to functions that are important to people with particular protected characteristics or to an area with known inequalities, discrimination or prejudice?
- Does it relate to any of the following 2013-16 equality objectives that SLaM has set?
  1. All SLaM service users have a say in the care they get
  2. SLaM staff treat all service users and carers well and help service users to achieve the goals they set for their recovery
  3. All service users feel safe in SLaM services
  4. Roll-out and embed the Trust’s Five Commitments for all staff
  5. Show leadership on equality through our communication and behaviour

<table>
<thead>
<tr>
<th>Name of the policy or service development:</th>
<th>Policy for Mortality Review</th>
</tr>
</thead>
<tbody>
<tr>
<td>Is the policy or service development relevant to equality, discrimination or good relations for people with protected characteristics below?</td>
<td></td>
</tr>
<tr>
<td>Please select yes or no for each protected characteristic below</td>
<td></td>
</tr>
<tr>
<td>Age</td>
<td>Disability</td>
</tr>
<tr>
<td></td>
<td>Y</td>
</tr>
</tbody>
</table>

If yes to any, please complete Part 2: Equality Impact Assessment

If not relevant to any please state why:

Date completed: 31/08/2017
Name of person completing: Lucy Stubbings
Service / Department: Nursing Directorate

Please send an electronic copy of the completed EIA relevance checklist to:

1. macius.kurowski@slam.nhs.uk
PART 2: Equality Impact Assessment

1. Name of policy or service development being assessed?
   POLICY FOR MORTALITY REVIEW

2. Name of lead person responsible for the policy or service development?
   Michael Holland, Medical Director

3. Describe the policy or service development
   What is its main aim?
   To provide guidance on the process of mortality review in order to ensure learning from deaths.
   What are its objectives and intended outcomes?
   Ensure that mortality reviews are completed in line with Trust policy and protocols
   What are the main changes being made?
   Not applicable – version 1
   What is the timetable for its development and implementation?

4. What evidence have you considered to understand the impact of the policy or service development on people with different protected characteristics?
   National Quality Board Guidance on Learning from Deaths

5. Have you explained, consulted or involved people who might be affected by the policy or service development?
   Consultation with Service leads, clinical working group and the Trust’s Mortality Review Group

6. Does the evidence you have considered suggest that the policy or service development could have a potentially positive or negative impact on equality, discrimination or good relations for people with protected characteristics?
   (Please select yes or no for each relevant protected characteristic below)

<table>
<thead>
<tr>
<th>Age</th>
<th>Positive impact: Yes</th>
<th>Negative impact: No</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

   Please summarise potential impacts:
<table>
<thead>
<tr>
<th>Category</th>
<th>Positive impact</th>
<th>Negative impact</th>
</tr>
</thead>
<tbody>
<tr>
<td>Disability</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>Please summarise potential impacts:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Timescale for review of deaths of people with a learning disability is extended, therefore more reviews will be completed</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Gender re-assignment</td>
<td>No</td>
<td>No</td>
</tr>
<tr>
<td>Please summarise potential impacts:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Race</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>Please summarise potential impacts:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Pregnancy &amp; Maternity</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>Please summarise potential impacts:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Religion and Belief</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>Please summarise potential impacts:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Sex</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>Please summarise potential impacts:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Sexual Orientation</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>Please summarise potential impacts:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Marriage &amp; Civil Partnership</td>
<td>N/A</td>
<td>N/A</td>
</tr>
<tr>
<td>(Only if considering employment issues)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Please summarise potential impacts:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Other (e.g. Carers)</td>
<td>Yes or No</td>
<td>Yes or No</td>
</tr>
<tr>
<td>Please summarise potential impacts:</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

7. Are there changes or practical measures that you can take to mitigate negative impacts or maximise positive impacts you have identified?

**YES:** Please detail actions in PART 3: EIA Action Plan

**NO:** Please explain why

*We don’t anticipate any negative impacts as a result of this policy.*
8. What process has been established to review the effects of the policy or service development on equality, discrimination and good relations once it is implemented?

Yearly review of policy, future audits will include further review of equality and characteristics of those who have mortality review completed.

Date completed: 31/08/2017  
Name of person completing: Lucy Stubbings  
Service / Department: Nursing Directorate

Please send an electronic copy of the completed EIA relevance checklist to:  
1. macius.kurowski@slam.nhs.uk
## PART 3: Equality Impact Assessment Action plan

<table>
<thead>
<tr>
<th>Potential impact</th>
<th>Proposed actions</th>
<th>Responsible/lead person</th>
<th>Timescale</th>
<th>Progress</th>
</tr>
</thead>
<tbody>
<tr>
<td>Review of equality impact assessment in June 2018 as part of Mortality Review Group</td>
<td>Lucy Stubbings</td>
<td>9 months</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Future Mortality Audit plan to include review of demographics on ePJS, CRIS data and Datix information.</td>
<td>Michael Holland</td>
<td>1 year</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Please send an electronic copy of the completed EIA relevance checklist to: macius.kurowski@slam.nhs.uk
Appendix 5. Human Rights Assessment

To be completed and attached to any procedural document when submitted to an appropriate committee for consideration and approval. If any potential infringements of Human Rights are identified, i.e. by answering Yes to any of the sections below, note them in the Comments box and then refer the documents to SLaM Legal Services for further review.

For advice in completing the Assessment please contact Anthony Konzon, Claims and Litigation Manager [anthony.konzon@slam.nhs.uk]

<table>
<thead>
<tr>
<th>HRA Act 1998 Impact Assessment</th>
<th>Yes/No</th>
<th>If Yes, add relevant comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>The Human Rights Act allows for the following relevant rights listed below. Does the policy/guidance NEGATIVELY affect any of these rights?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Article 2 - Right to Life [Resuscitation /experimental treatments, care of at risk patients]</td>
<td>No</td>
<td></td>
</tr>
<tr>
<td>Article 3 - Freedom from torture, inhumane or degrading treatment or punishment [physical &amp; mental wellbeing - potentially this could apply to some forms of treatment or patient management]</td>
<td>No</td>
<td></td>
</tr>
<tr>
<td>Article 5 – Right to Liberty and security of persons i.e. freedom from detention unless justified in law e.g. detained under the Mental Health Act [Safeguarding issues]</td>
<td>No</td>
<td></td>
</tr>
<tr>
<td>Article 6 – Right to a Fair Trial, public hearing before an independent and impartial tribunal within a reasonable time [complaints/grievances]</td>
<td>No</td>
<td></td>
</tr>
<tr>
<td>Article 8 – Respect for Private and Family Life, home and correspondence / all other communications [right to choose, right to bodily integrity i.e. consent to treatment, Restrictions on visitors, Disclosure issues]</td>
<td>No</td>
<td></td>
</tr>
<tr>
<td>Article 9 - Freedom of thought, conscience and religion [Drugging patients, Religious and language issues]</td>
<td>No</td>
<td></td>
</tr>
<tr>
<td>Article 10 - Freedom of expression and to receive and impart information and ideas without interference. [withholding information]</td>
<td>Np</td>
<td></td>
</tr>
<tr>
<td>Article 11 - Freedom of assembly and association</td>
<td>No</td>
<td></td>
</tr>
<tr>
<td>Article 14 - Freedom from all discrimination</td>
<td>No</td>
<td></td>
</tr>
</tbody>
</table>

Name of person completing the Initial HRA Assessment: Lucy Stubbings, Head of Patient Safety
<table>
<thead>
<tr>
<th>Date:</th>
<th>30/08/2017</th>
</tr>
</thead>
<tbody>
<tr>
<td>Person in Legal Services completing the further HRA Assessment (if required):</td>
<td></td>
</tr>
<tr>
<td>Date:</td>
<td></td>
</tr>
</tbody>
</table>
REPORT TO THE TRUST BOARD: PUBLIC
28th November 2017

Title | COUNCIL OF GOVERNORS’ REPORT
---|---
Author | Charlotte Hudson
Accountable Director | Rachel Evans

Purpose of the paper
To update the Board on the recent activity of the Council of Governors.

Governor elections
1. Voting in the Governor elections closed at 17.00 on 9 November 2017. Jenny Cobley, Gill Sharpe and Handsen Chikowore were all re-elected in the Public Governor constituency and will be joined by James Canning and Ruth Govan. In the Service User category, Kathryn Grant was appointed. From the staff, Giles Constable, Emma Williamson and Ermias Alemu will be joining the Council of Governors.

2. All newly-appointed Governors will take up their roles in December 2017 and have been invited to join a bespoke induction afternoon at the Maudsley Hospital on 30 November. The new on-site Governor training has been designed using feedback from existing Governors in order to provide a comprehensive introduction to the role of a Governor, the context at SLaM and what to expect at Council of Governor and Working Group meetings.

3. The Council of Governors would like to thank those Governors who have stood down or who have reached the end of their terms for their work and commitment, including Marnie Hayward, Chair of the Quality Working Group; David Blazey, Chair of the Bids Steering Group; Alan Hall; Francis Keaney; John Muldoon and Siobhan Netherwood.

Council of Governors / Non-Executive Directors meeting
4. Representatives of the Council of Governors had an hour-long meeting with the NEDs directly before October’s Board meeting.

5. The Governors raised a number of issues with the NEDs, including the welfare of staff working in the community; parking arrangements; mental health funding; the nursing directorate consultation and CCG structures. The Governors also sought assurance regarding the cost efficiency and benefits of the QI initiative.

Membership & Involvement Group
6. The Membership and Involvement Group met on 7 November. Among the topics discussed was a proposition to pilot a new way of engaging with SLaM’s membership by joining existing community events and groups in order to reach a wider audience.
The Group agreed to use this opportunity to apply QI methodology to the pilot scheme.

STP event

7. A South-East London Sustainability and Transformation Partnership (STP) meeting was held on 7 November for NEDs, Governors and lay members. The Chief Executive of Southwark CCG gave a presentation on the re-organisation of the CCGs within the STP. Jenny Cobrely, John Muldoon and June Mulroy attended from SLaM.

Visit: MHOAD, Lewisham

8. On 8 November, two of the Governors, Brian Lumsden and Bert Johnson, visited Lewisham MHOAD services – the Memory Service, the Community Mental Health Team for Older Adults and the Care Home Intervention Team at 91 Granville Park, along with Roger Paffard and Anna Walker.

9. Those attending were struck by the commitment and care towards patients demonstrated by the staff. QI methodology has been rolled out to a number of projects designed to improve quality.

Nominations Committee

10. The Nominations Committee met on 9 November and discussed proposed processes for appraisal of the Chair and Non-Executive Directors, as well as reviewing NED remuneration using benchmarking data.

Bids Steering Group

11. The Bids Steering Group met on 9 November and considered bids under the Let’s Smile Scheme.

Quality Working Group

12. The Quality Working Group met on 14 November. It was Marnie Hayward’s last meeting at Chair, and Rosie Mundt-Leach was elected as her successor. It was agreed that given Rosie’s position as a Staff Governor, steps would be taken to ensure that the new Deputy Chair of the group would not be from the same constituency and could therefore act as an independent substitute should there be a perceived conflict of interest arising.

13. The QWG heard from the Acute CAG on the role of the Modern Matron, and commends this initiative as a future Board item. The Director of Nursing also attended the meeting and gave a thorough and candid report on the action plan arising from the recent CQC Adult Community Pathway re-inspection.

Planning and Strategy Working Group

14. At the time of writing, the Planning and Strategy Working Group is due to meet on 21 November and receive presentations from the Chief Operating Officer and the Director of Strategy and Communications.

National Lead Governor Association

15. On 15 November, Jenny Cobrely attended a meeting of Lead Governors from around the country, at which it was agreed to form a National Lead Governor Association (NLGA).
COMMITTEE REPORT TO THE TRUST BOARD: PUBLIC
28th NOVEMBER 2017

Title
EQUALITIES AND WORKFORCE COMMITTEE UPDATE

Non-Executive Director
Roger Paffard, Chairman

Purpose of the paper

This is a regular report to the Board which sets out:
- the key issues discussed at the Committee meeting and the actions proposed;
- the key points of assurance;
- the key risks that the Chair or the Committee wish to flag; and
- any issues to flag to other Committees.

The Board is asked to note the report which is presented for information and discussion.

KEY ISSUES SUMMARY

<table>
<thead>
<tr>
<th>Terms of reference were agreed subject to small amendments</th>
<th>None required</th>
</tr>
</thead>
<tbody>
<tr>
<td>The overall equalities and workforce action plan was presented and discussed. The plan will be developed into a series of QI style driver diagrams with metrics to track progress.</td>
<td>Metrics to be drafted by mid December 2017</td>
</tr>
<tr>
<td>An update on band 5 and CPN recruitment was presented and progress noted.</td>
<td></td>
</tr>
<tr>
<td>The Trust’s participation in cohort 2 of the NHSI retention initiative was presented, and the extent to which the Trust is already adopting much of the recommended practice was noted.</td>
<td>Further reports will be brought to the Committee in due course.</td>
</tr>
<tr>
<td>Staff survey responses to date were reported.</td>
<td>Action plan to improve response levels through incentives and introducing competition between CAGs, directorates and departments. The results will be available in early 2018.</td>
</tr>
<tr>
<td>The launch of the SLP wide Nurse Development Programme consultation was noted.</td>
<td>Consultation closes in early December and the launch of the programme is scheduled for early in 2018.</td>
</tr>
<tr>
<td>Ongoing collaborative work across the SLP on workforce issues including shared services was reported.</td>
<td></td>
</tr>
</tbody>
</table>

Key points of assurance

The Committee was provided with assurance, across the breadth of the equalities and workforce agenda, that actions have been defined and that resources are being identified to deliver these within the timeframes agreed by the Board.
### Key risks to flag

Essential (including mandatory and statutory) training compliance has shown steady improvement but some elements remain below target. Detailed remedial action plans are in progress.

### Issues to be brought to the attention of other Committees

Essential (including mandatory and statutory) training compliance and remedial action plans to be brought to the Quality and Safety Committee.
REPORT TO THE TRUST BOARD: PUBLIC

28 November 2017

Title | Performance Report
---|---

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

Accountable Director | Kristin Dominy, Chief Operating Officer

**Purpose of the paper**

To report the Trust’s operational performance against a range of key national indicators and identify and analyse under-performance and report action plans.

The report summarises the Performance Management Framework review meetings and identifies any major areas of learning and success.

To report on current contractual matters arising and key areas of focus for the Project Management Office.

To report on emergency preparedness status and current actions.

**Executive Summary:**

The Trust continues to meet the performance-related NHS Improvement Single Oversight Framework indicators with the exception of IAPT recovery. There are a number of risks and associated actions set out in the report.

The pressures across the acute pathway (inpatient and community) remain significant. Lambeth and Lewisham have significantly higher levels of inpatient bed usage than planned; actions continue to be based on a whole system approach covering both inpatient and community services to achieve the necessary flow.

CIP delivery shows a forecast variance of £5.3 million behind plan. The PMO is working with all underperforming CAGs and departments to develop emerging schemes to close the gap, however much of the recovery is non-recurrent and while closing the gap this year, will require further recurrent savings next year.

The contract refresh discussions to confirm 2018/19 (the second year of the 2017/19 contracts) are critical to ensure areas of pressure are addressed including any gap between the contract values, QIPP plans and the finance available for services. Escalation meetings with the Chief Operating Officer have commenced. An escalation meeting is planned with NHS England for their 1718 QIPP programme.
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Appendix A – September Performance Dashboard
Appendix B – September Quality Sub Committee Dashboard
1. Report Format and Summary
The format for this Board report has been updated to include additional trend information and reference to planned activity levels. A review is taking place in the coming months to create a more succinct style whilst ensuring all aspects of Trust performance are covered and not sacrificing detail.

The following areas of the report contain noteworthy risks:

- NHSI indicators – IAPT performance
- Inpatient activity
- Liaison A&E presentations
- Community activity – A&L, HTT and EI caseloads
- Commissioning – financial pressures emerging in 1819 contract refresh and QIPP – Placements, NHS England Specialist Services and Lewisham community teams
- CQUINs
- CIPs - £5.3 million behind plan

2. NHS Improvement Indicators
NHS Improvement indicators for the Single Oversight Framework are detailed below, in addition to being reported to the Finance and Performance committee (Access and Effectiveness indicators) and the Quality Sub-Committee (Quality indicators). Performance for October is being validated at the time of writing.

The key risks identified for NHSI indicators are:

- EI 2 week standard - caseloads
- IAPT waiting times
- IAPT recovery rate

2.1 NHSI Indicators: Access, Effectiveness and Quality

2.1.1 Home Treatment Team Gatekeeping

![HTT Gatekeeping](image)

Fig. 1 NHSI Indicators: HTT Gatekeeping.

The Trust has consistently achieved in excess of the 95% target this financial year with the latest data reporting 100% achievement.
2.1.2 Early Intervention in Psychosis 2-week standard

![EI 2 week standard graph]

Fig. 2 NHSI Indicators: Early Intervention in Psychosis

The Trust has consistently achieved in excess of the 50% target this financial year although delivery has been falling over recent months. The risks associated with this standard are:

- Concerns about delivery of part two of the standard based on existing CCG investment, the rising caseloads and the projected 70% total caseload increase over three years. Of particular concern is the ability of the Croydon team to move to expanding the service to those over 35 years old.
- Progress has been made in readiness for the migration to reporting through MHSDS. This change involves the reporting moving to system data as opposed to an end of month manual process.

2.1.3 IAPT Waiting Times

![IAPT Waiting 6 week standard graph]
Fig. 3 NHSI Indicators: IAPT Waiting Time Standards

The Trust has consistently achieved in excess of the 6 week and 18 week targets this financial year. The risks associated with this standard are:

- Trust provision is affected by the reduced service commissioned by Croydon CCG targeting 12% access against the national CCG target of 16.8% access for population with depression or anxiety disorders.
- Following disinvestment from the CCG, The Lewisham IAPT service has not met the 6 week standard for the last 3 months, although performance improved in September. This is being reviewed and addressed by the team.

2.1.4 IAPT Recovery

Fig. 4 NHSI Indicators: IAPT Recovery Rate
NHS Digital continues to publish the official statistics for these measures. The most recent time period published at the time of writing is July 2017.

- Southwark 36%
- Lewisham 53%
- Croydon 50%
- Lambeth 50%

Provisional data from internal reporting for September indicates the Trust remains below the 50% standard at 47.2% and overall performance for this financial year based on internal Trust reporting is also below the 50% standard.

The most recent data indicates Lewisham, Lambeth and Croydon are sustaining an element of improvement although the Croydon service has been impacted by the significant cuts requested by commissioners as part of the implementation of the Croydon Affordability Bridge in June 2016 and Croydon CCG focus on access targets. There was also disinvestment by Lewisham CCG in 2017/18.

Southwark performance continues to be addressed in liaison with Southwark CCG. SLaM have invited NHSI to return to the Trust in December to review and advise on the improved reporting processes, in addition to initiating an internal audit to review all IAPT submissions. The Southwark recovery plan is based on a combination of improved reporting and changes to the service model. It is expected that the 50% target will be achieved in Q1 2018/19.

2.1.5 IAPT Payment By Results
There is a national initiative to change the mechanism by which IAPT services will receive income from April 2018. The change is intended to move to activity and outcomes and a local plan will be introduced in shadow form for monitoring from January 2018 in preparation for the April payment transition. There has been limited detailed guidance for the new tariff system beyond a proposal to incorporate activity, clinical outcomes and the use of the mental health clustering tool. The use of clustering is being reinforced within our IAPT teams.

2.1.6 7 Day Follow Up

![CPA follow up within 7 days of discharge](image)

**Fig. 5 NHSI Quality Account Indicator: 7 Day Follow Up**

The Trust has consistently achieved in excess of 95% this financial year.
Whilst Seven Day follow-up no longer has a national target attached in the SOF (was 95%), it remained a mandated component of the 2016/17 Quality Account. Given the importance of the measure and the potential for inclusion in the 2017/18 Quality Account, it will continue to be monitored and reported to the Board.

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

2.2 Business Intelligence

2.2.1 Data Quality for Mental Health Services Data Set submissions
The next version MHSDS, version 3, will be introduced in April 2018. This change is required to meet the ambitions set out in ‘Achieving Better Access to Mental Health Services by 2020’ and ‘The Five Year Forward View’ for Mental Health (MHFYFV). NHS Digital are working with the mental health access and waiting time standards programme to ensure that agreed methodologies can be reported from the MHSDS for the following care pathways: Adult acute mental health, CYP mental health, CYP eating disorders, EIP, Perinatal mental health and Urgent and Emergency mental health. This will allow commissioners to monitor the defined care pathways (specifically access and waiting times) using pre-defined metrics.

The Business Intelligence Team are currently undertaking a gap analysis to understand the required changes to the clinical information system, ePJS.

Any changes will be validated by the Clinical Systems Team (Digital Services) and development requests will be made to the supplier where required. In parallel, the Trust data warehouse is being developed to meet the requirements of the MHSDS v3 and will be the source of all submissions from April 2018.

This approach allows incident data to be included directly from Datix and staff professional registration details from LEAP/ESR. Test submissions will be made throughout Quarter 4 2017/18 and data quality reports will be developed, using the Microsoft Power BI platform, to ensure that data is valid, accurate and complete.

This early testing phase will enable the data extract mechanism to be finely tuned. Several members of the BI Team have attended the national stakeholder event and will participate in the national discussion and share best practices. In Quarter 1 2018/19, focus will move to the analysis of MHSDS v3 submissions so that the data quality and performance can be fully understood.

The project aims to deliver a suite of reports and dashboards to clinical services. It is hoped that this will aid understanding of historic and current data quality issues and provide insight and improvement opportunities. This new facility will allow the Trust to look ahead and determine national figures before publication. This insight can then be utilised within the Trust and shared with commissioners. Data quality issues can then be identified, analysed, and be used to inform the data warehouse extraction process, creating a necessary feedback loop.

2.2.2 Improving the clinical service directory
The Trust has recognised the need to improve the relationship between its corporate information systems and the clinical service directory by aligning them both to an agreed list of clinical services. This alignment allows analysis of services, using information across multiple domains, to better understand the performance of clinical services. The Quality Improvement team is assisting with this challenge as a successful outcome promotes the development of clinically relevant, weighted indicators, such as the ‘Number of Incidents per Occupied Bed Day’. Excellent progress has been made in both the reconciliation of the differing iterations of the service directory and in the
introduction of a new interim change management process. This new change process has allowed focus to be placed on other strategic priorities, whilst providing an opportunity to plan and develop a new sustainable solution for implementation in Quarter 4 2017/18.

2.2.3 Demand for access to information and the need for Statistical Process Control (SPC) capabilities
There has been significant interest and a continuous stream of requests for access to and report development in the new Power BI software. This demand has led to a growth in the number of required Power BI licences and this trend is set to continue as new interactive dashboards are introduced. There is now a need to evaluate how to expand access to Power BI across the entire organisation. The initial implementation allowed for 500 licences at an equivalent cost of around £45K per year. A proposal is being evaluated which will increase access to another 4,500 for a further £50K per year.

The Quality Improvement programme requires the use of SPC charts and this functionality is being explored within Power BI, using an embedded statistical programming language, ‘R’. The Chief Information Officer has committed to engage Microsoft, with the aim of obtaining the support required to fulfil SPC reporting requirements. In parallel, the Trust is exploring an alternative SPC charting solution, Lightfoot SfN. Both SPC solutions will be evaluated in January 2018 and a discussion paper will be provided to the Trust SMT in February 2018.

3 Operational Performance and Activity
3.1 In-Patient Activity and Performance
In order to improve the tracking of performance against contract, the following run charts show the performance of the adult acute inpatient services for LSLC patients against the LSLC contract values. These figures include foreign patients for which a further accounting adjustment is made (usually reducing the activity by c. 2%).

The charts show performance on a monthly basis for 19 months from April 2016 to October 2017 with the planned levels through to March 2018. In order to enable monthly comparison, the number of OBDs is divided by the number of days in the month and therefore also provides the equivalent to monitoring bed usage. Data excludes leave and the data combines Acute, Triage, PICU and Early Intervention wards (including all overspill).

Due to the 16/17 performance, contract negotiations agreed an increase in the contracted number of OBDs in April 2017 (ie month 13). However, Q4 performance meant that performance was already above the plan at the start of the 17/18 year and recovery plans are in place aligned with the QI Large Scale Initiative. The external overspill chart appears later in this report.

Of particular note is the excess OBD position in Lambeth (c. 25% excess in Q2) and Lewisham (c. 15% excess in Q2). A forecast year end position and risk share has been confirmed and recovery trajectories are being finalised.

Whilst starting from a relatively high base, the Croydon improvement is a highlight and can be seen to be the key driver in the overall Trust position. In fact, Q2 performance for Croydon was 9% ahead of plan for Q2. For all CCGs, Q3 and 4 require continued reductions in bed usage.
In addition to the variance against contract, external overspill adds an additional cost pressure to the Trust. Eliminating external overspill aligns closely to the Mental Health Five Year Forward View target and the Crisp report recommendation to eliminate out of area placements; as such, there is a national focus on Out of Area Placements (OAPs). Both the SEL and SWL STPs are reporting the Trust status for OAPs based on the definition of external overspill (i.e. only counting those patients in non-SLaM beds). There is an emerging debate whether overspill should be assessed on borough boundaries within Trusts and this would result in all Croydon patients potentially being considered as OAPs due to the Bethlem site being located in the borough of Bromley. The STPs are engaging with the national centre to agree an appropriate, helpful, definition.

There continues to be a reducing, low level of usage of external OAPs. Fig. 7 shows the position from April 2017 through to the first weeks in November, the colours represent the split between Acute and PICU beds.

Fig. 7 – External Overspill, April 2017 through to mid November 2017
As part of the QI Large Scale Initiative (LSI), community teams and inpatient wards in each of the four boroughs have developed ideas for improvement projects, working towards the overall aims of reducing length of stay, keeping people well in the community to reduce avoidable admissions, and to improve patient experience. An important component of the plan is to adapt and test “red to green” bed days in four wards with a view to spreading this to other wards if successful.

Projects per borough:

<table>
<thead>
<tr>
<th>Borough</th>
<th>Number</th>
</tr>
</thead>
<tbody>
<tr>
<td>Croydon</td>
<td>6</td>
</tr>
<tr>
<td>Lambeth</td>
<td>12</td>
</tr>
<tr>
<td>Lewisham</td>
<td>5</td>
</tr>
<tr>
<td>Southwark</td>
<td>7</td>
</tr>
</tbody>
</table>

Types of projects:

<table>
<thead>
<tr>
<th>Category</th>
<th>Number</th>
</tr>
</thead>
<tbody>
<tr>
<td>Smoothing admissions process</td>
<td>3</td>
</tr>
<tr>
<td>Improving clinical care for complex patients</td>
<td>2</td>
</tr>
<tr>
<td>Improving communication across boundaries</td>
<td>4</td>
</tr>
<tr>
<td>Increasing discharges</td>
<td>12</td>
</tr>
<tr>
<td>Improving patient experience</td>
<td>6</td>
</tr>
<tr>
<td>Reducing risk</td>
<td>3</td>
</tr>
</tbody>
</table>

3.1.1 Occupied Bed Days: Acute Care Pathway

Fig. 8 – Length of Stay Breakdown
Patients with longer lengths of stay are reviewed weekly at clinical meetings. Longer lengths of stay can be attributable to delayed transfers of care, other reasons of social need and patient acuity. A higher proportion of current patients in Croydon and Lewisham wards and private overspill have a length of stay over 6 months.

Figure 8 clusters the inpatient cohort within the acute care pathway (wk2, November) by their length of stay at that point. The first colour is 0-30 days, then 31-60 days and the final group is >180 days. The commissioners are in alphabetical order: Croydon, Lambeth, Lewisham, Southwark and "other". Lambeth CCG can be seen to have the highest number of inpatients and the highest number (13) whose length of stay already exceeds 180 days.

Regular interface meetings between Community and Inpatient wards are occurring with a particular focus on strengthening the joint working and awareness between community teams and wards.

3.1.2 LSLC Admissions

The following charts show the admissions by CCG for each month Apr 16 – Oct 17 with planned levels through to March 2018. The planned level was based on historical performance in 2016 and was set at a flat, consistent rate. It can be seen that admission levels are broadly consistent although usually above the planned level which has been contributing to the increased levels of inpatient activity. The number of admissions reduced in October and if this reduction continues, balancing measures will be developed.

![Graph showing LSLC admit daily equiv from Apr16](image1)

![Graph showing Lambeth admit daily equiv from Apr16](image2)
3.1.3 Delayed Transfers of Care

The Trust makes a monthly submission to NHS England providing a snapshot of delays and lost bed days. The charts below plot these overall submissions alongside the most recent split across the different boroughs. The reporting is by local authority as the reason for delay can be attributable to NHS or social care.

In September, the Trust recorded 605 bed days being lost to delayed transfers of care. At 2.8%, this brings the Trust under the 3.5% target set from September by NHSE. Clearer definitions for DToCs are being documented and the process for agreeing and recording DToCs is being standardised across the Trust. This complements the existing weekly calls where DToCs are discussed.

Fig. 9 – LSLC Admissions by month
Figure 11 describes the number of days lost by local authority. The attribution of responsibility for delays process follows NHS England guidance and attribution agreed in consultation with local authorities.
3.2 Community Activity & Performance
Overall, the community picture remains one of increasing pressure in many areas of the system and this is being shared with commissioners to support their decision making.

3.2.1 A&E Mental Health Liaison
The number of presentations to A&E Mental Health Liaison teams have increased in Croydon and Southwark since the beginning of this year and these boroughs are up to 46% above indicative activity plans.
### 3.2.2 Community Teams

Recent Board Reports have highlighted the increasing growth in Assessment & Liaison caseloads and the associated pressure has resulted in the teams adjusting their thresholds of care in order to achieve a more realistic caseload. These reviews are on-going and a further update will be provided in due course.

The following graphs highlight a continued growth in the caseload size of our Home Treatment and Early Intervention teams. The updated information to October 2017 is shown in Figs. 13 and 14 with the impact of the changes to the Home Treatment Teams in October 2016 clearly visible.
Fig. 13  Adult Home Treatment Team caseload, referrals and discharges Apr 16 – Oct 17

Fig. 14  Early Intervention caseload, referrals and discharges Apr 16 – Oct 17
4. CAG Performance Reviews Summary

The Performance Management Framework is comprised of Key Performance Indicators across:
- Finance (including cost improvements and cost reductions)
- Operations (workforce, activity and quality indicators)
- Patient and commissioner measures
- Learning and growth

The key issues and associated actions remain consistent:
- Adult inpatient pathway pressures; external overspill and Delayed Transfers of Care (DToC) – the full system approach to tackling this has now commenced although significant pressure remains in this area
- Placements (Southwark and Lewisham)
- IAPT performance
- Early Intervention
- Delivery of CIP schemes for 17/18 and identifying additional opportunities given the on-going CIP gap.
- Implementation of QIPP plans and other commissioner cost reduction plans in response to commissioned schemes
- Agency expenditure and achieving the NHSI reduction trajectory

4.1 Training

4.1.1 Mandatory Training Compliance (September 2017)
Overall mandatory training compliance increased slightly in September to 81.64%.

As reported in August, the creation of accounts for new starters and honorary post-holders continues to be a challenge which impacts on the induction process and the department’s commitment to ensure that individuals working on behalf of the Trust have the right knowledge and skills to perform their duties safely and effectively.

4.1.2 Physical Health Level 1 Awareness
In accordance with the Trust’s CQUIN targets, all staff are required to complete a level 1 awareness course on physical health. Since April, a session on physical health has been delivered to all new starters at Trust Values Day. Existing staff can now complete the training by watching a 15 minute interactive video either individually through LEAP or as a group in a team meeting. Overall compliance stood at 55.29% on 2 October.
 Tier | Renewal Period | Certification Name | Tier 1 Level A | Tier 1 Level B | Tier 2 Level A | Tier 2 Level B | Tier 3 Level A | Tier 3 Level B |
<table>
<thead>
<tr>
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</thead>
<tbody>
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<td>Tier 1 Level A</td>
<td>3 Years</td>
<td>Advanced Life Support</td>
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<td>100.00%</td>
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<tr>
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<td>Mental Health Act Training</td>
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<td>96.00%</td>
<td>94.00%</td>
<td>94.00%</td>
</tr>
<tr>
<td>Tier 1 Level A</td>
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<td>Health and Safety for Managers</td>
<td>90.00%</td>
<td>98.00%</td>
<td>96.00%</td>
<td>96.00%</td>
<td>94.00%</td>
<td>94.00%</td>
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<tr>
<td>Tier 1 Level B</td>
<td>3 Years</td>
<td>Health, Safety and Welfare</td>
<td>90.00%</td>
<td>98.00%</td>
<td>96.00%</td>
<td>96.00%</td>
<td>94.00%</td>
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<tr>
<td>Tier 1 Level A</td>
<td>3 Years</td>
<td>Immediate Life Support - DSN</td>
<td>90.00%</td>
<td>98.00%</td>
<td>96.00%</td>
<td>96.00%</td>
<td>94.00%</td>
<td>94.00%</td>
</tr>
<tr>
<td>Tier 1 Level B</td>
<td>3 Years</td>
<td>Health and Safety and Welfare</td>
<td>90.00%</td>
<td>98.00%</td>
<td>96.00%</td>
<td>96.00%</td>
<td>94.00%</td>
<td>94.00%</td>
</tr>
<tr>
<td>Tier 1 Level A</td>
<td>3 Years</td>
<td>Prevent Awareness</td>
<td>90.00%</td>
<td>98.00%</td>
<td>96.00%</td>
<td>96.00%</td>
<td>94.00%</td>
<td>94.00%</td>
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<tr>
<td>Tier 1 Level B</td>
<td>3 Years</td>
<td>Prevent Workshop</td>
<td>90.00%</td>
<td>98.00%</td>
<td>96.00%</td>
<td>96.00%</td>
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<tr>
<td>Tier 1 Level A</td>
<td>3 Years</td>
<td>PCTS Team Work</td>
<td>90.00%</td>
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<td>96.00%</td>
<td>96.00%</td>
<td>94.00%</td>
<td>94.00%</td>
</tr>
<tr>
<td>Tier 1 Level B</td>
<td>3 Years</td>
<td>PCTS Team Work - DSN</td>
<td>90.00%</td>
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<td>96.00%</td>
<td>96.00%</td>
<td>94.00%</td>
<td>94.00%</td>
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**Fig. 15** Mandatory Training Tier 1 Levels A & B
5. Commissioning

The contract refresh in 2019 is taking place. At the time of writing, the first round of meetings have been completed with LSLC commissioners along with a joint 4 Borough meeting with CAG leadership teams. 2018/19 will be the second year of the existing two year contracts and commissioners have confirmed a consistent approach regarding their plans and priorities for mental health services. However, during November it is becoming apparent that the financial stress across our broader health economy is having an impact on commissioner plans for investment. Additionally, there is an emerging picture of limited or no QIPP plans to support planned reductions in the SLaM contract value. Escalation meetings with the Chief Operating Officer have taken place with Lewisham and Croydon supported by the Director of Finance and Chief Financial Officer.

Croydon CCG continues to face a significant financial challenge. The Trust is awaiting confirmation of the Croydon CCG proposals for Specialist Services in writing, although there has been clarification that decisions will be made based on clinical need as a priority over financial constraints except for a proposed “one in one out” system for the National Autism Unit. The need for this clarification was again highlighted in the October core contract meeting.

The Older Adult Outcomes Based Commissioning (OBC) Alliance and the Mental Health commissioning team is improving co-ordination and alignment with the existing Mental Health Programme Board acting as a focal point for all mental health proposals. The CCG intends to extend the scope of the OBC Alliance to adults of all ages and the SLaM Executive has expressed their lack of confidence in the ability of the programme to encompass this expansion. This matter remains under review. The priority investment areas for the existing Older Adult OBC Alliance to consider have been sent to commissioners and the OBC team to include in the business plan. Waits for memory services remain excessively long due to cuts in funding for the service and this is being tackled through both the OBC discussions and the 1819 contract refresh.

The Lambeth Alliance proposals are now being managed through a number of workstreams. The target date remains 1st April 2018 and there is an awareness that there will be limited changes initially with the expectation of a continuing evolution of the existing Integrated Personalised Support Alliance (IPSA). As part of the SLaM contract refresh, Lambeth commissioners have confirmed their intention to reduce the contract value by £1 million and the impact on the Alliance is being considered.

The BDP CAG has highlighted quality concerns for the ASD / ADHD service in Lewisham. Demand significantly exceeds capacity of this clinic, which has resulted in high waiting times for patients - approaching 2 years. In response, the service is communicating the long waiting times to referrers. The Quality Impact Assessment and options paper has been shared with Lewisham CCG to address the current capacity and demand issues. Lewisham commissioners had requested for SLaM to source the necessary additional funding from elsewhere within the block and they have been informed this is not a viable option.

In addition to the focus on IAPT in Southwark, there is continued pressure on placements. The programme of work developed in response to the QIPP has reduced the amount of growth and the impact is being shared with the commissioners to inform future plans. Additionally, responses have been sent to the local authority regarding their plans for CAMHS services.

It is pleasing to be able to report that approval was granted at JOSC on 6th November to redesign the older adults acute inpatient pathway. This broadly means that patients can be admitted to a ward environment that meets their clinical need. Chelsham House will be the acute dementia unit and the other two wards, AL1 and Hayworth, will admit people with a functional illness.
Southwark CCG are developing plans to consider forming an Alliance for mental health services which could take a similar format to the Lambeth system.

There will be a review of NHS England CQUIN and QIPP schemes after Q2 to confirm the process for SLaM to invoice for the value of the QIPP to be returned to the baseline (NHS England remove the QIPP value from the contract at the start of the year). Commissioners have confirmed their belief that the CQUIN actions will realise sufficient repatriation to release the value of the QIPP back to SLaM.

Various initiatives under the Five Year Forward View (5YFV) are now proceeding and a system of oversight is being implemented with commissioners, using a simple template for each initiative referencing the national expectation and any local modifiers. The Psychological Medicine and Integrated Care CAG is leading on this given the current focus on IAPT, Core 24 liaison services and Perinatal services. This oversight of the implementation and results achieved will be particularly important to assist our negotiations for making the new funding recurrent and part of our core contracts in the future. This will align with the STP reporting of the 5YFV.

5.1 Commissioner-related Quality Impact Assessments (QIAs)

The Programme Management Office (PMO) has managed QIAs for CIP schemes and this is extending to include commissioner-related QIAs including the Quality, Innovation, Productivity, and Prevention (QIPP) programme. Frequent rescheduling of QIA panels has resulted in the expiry of many QIPP QIAs, in some cases the change has already occurred despite not having a quality impact assessment. The system is currently relying on the assurance of QIPP delivery leads that quality is not adversely affected rather than a robust QIA process. The PMO is introducing a governance RAG alongside the CSO delivery RAG to more readily report failures in governance such as QIA, risk management and delivery planning.

5.2 Commissioning Programmes 2017-18

2017-18 QIPP and CQUIN schemes are being managed using the PMO principles.

5.2.1 Quality, Innovation, Productivity and Prevention (QIPP) programme

QIPP has been rated into four categories:

<table>
<thead>
<tr>
<th>Rating</th>
<th>Definition</th>
<th>£'000s</th>
</tr>
</thead>
<tbody>
<tr>
<td>Red</td>
<td>Requires significant work</td>
<td>2,651</td>
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<tr>
<td>Amber</td>
<td>Requires some work</td>
<td>600</td>
</tr>
<tr>
<td>Green</td>
<td>Requires little work</td>
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</tr>
<tr>
<td>Blue</td>
<td>Delivered</td>
<td>2,775</td>
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<td>Total</td>
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<td>10,250</td>
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The QIPP risk dashboard is below:
<table>
<thead>
<tr>
<th>QIPP Ref</th>
<th>CCG</th>
<th>QIPP plan</th>
<th>progress</th>
<th>CAG</th>
<th>Value (£)</th>
<th>RAG</th>
<th>Forecast (£)</th>
</tr>
</thead>
<tbody>
<tr>
<td>QIPP01</td>
<td>Southwark</td>
<td>Residential placements structure of teams</td>
<td>Action plans agreed, case being prepared for discussion with commissioner</td>
<td>Psychosis</td>
<td>800,000</td>
<td>0</td>
<td>0</td>
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<tr>
<td>QIPP11</td>
<td>Lewisham</td>
<td>Lewisham Community Teams - A&amp;L Team</td>
<td>Split 50:50 PMIC Psychosis - both failing to deliver</td>
<td>PMIC &amp; Psychosis</td>
<td>208,000</td>
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<td>0</td>
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<tr>
<td>QIPP19</td>
<td>NHS England</td>
<td>PMIC C&amp;V Services</td>
<td>NHS plans not produced, full amount at risk</td>
<td>PMIC</td>
<td>445,000</td>
<td>0</td>
<td>165,000</td>
</tr>
<tr>
<td>QIPP07</td>
<td>Lewisham</td>
<td>Reduction in Placements Funding cost centre overspending by £379k</td>
<td></td>
<td>Psychosis</td>
<td>365,000</td>
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<tr>
<td>QIPP17</td>
<td>NHS England</td>
<td>Tier 4 Acute Adolescent Inpatient Kent - (FYE 16/17)</td>
<td>NHSE Kent, Surrey, Sussex have not engaged proactively with QIPP</td>
<td>CAMHS</td>
<td>833,408</td>
<td>833,408</td>
<td>833,408</td>
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<td>QIPP01</td>
<td>Southwark</td>
<td>Increase in cross boundary flow income from Surrey/Sussex</td>
<td>Dispute with CCG on ownership</td>
<td>Acute Care / Psychosis</td>
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<td>600,000</td>
<td>600,000</td>
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<tr>
<td>QIPP04</td>
<td>Southwark</td>
<td>Contribution of housing to DTGC (delayed transfers of care) - will require a £200k reduction in obsd</td>
<td>CIP over delivers against QIPP, Bedstock will be reassessed after CIP is delivered. This results in reduced impact of CIP as £2.7m OBD cost is taken as QIPP. This is already accounted for in financial plan.</td>
<td>Acute Care</td>
<td>2,742,331</td>
<td>2,742,331</td>
<td>2,742,331</td>
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<tr>
<td>QIPP03</td>
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<td>Treatment teams redesign (KD leading health based model)</td>
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<td>200,000</td>
<td>200,000</td>
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<tr>
<td>QIPP18</td>
<td>NHS England</td>
<td>Secure &amp; Specialised MH - secure male</td>
<td>CAG confirmed action is complete. SLaM agreement with NHSE to reduce QIPP target with each repatriation must be tested against SLP finance arrangements</td>
<td>BDP</td>
<td>764,855</td>
<td>764,855</td>
<td>764,855</td>
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<tr>
<td>QIPP10</td>
<td>Lewisham</td>
<td>LITT Team - move from Psychosis to primary</td>
<td>Degree final transition model with CCG</td>
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<td>217,000</td>
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<tr>
<td>QIPP16</td>
<td>Croydon</td>
<td>Reduction in IAPT Costs/Activity</td>
<td>Contract reduced and team removed but overhead contribution will not be saved resulting in £67k pressure centrally</td>
<td>PMIC</td>
<td>300,000</td>
<td>300,000</td>
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<tr>
<td></td>
<td>Croydon (Bridge)</td>
<td>FYE delivery</td>
<td>Closed</td>
<td>Multiple</td>
<td>1,059,000</td>
<td>1,059,000</td>
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<tr>
<td>QIPP05</td>
<td>Lewisham</td>
<td>Withdrawal from START (FYE from 1/7/16)</td>
<td>Complete</td>
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<tr>
<td>QIPP06</td>
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<td>CASCAID (FYE from 1/7/16)</td>
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<td>QIPP12</td>
<td>Lewisham</td>
<td>Direct Payment Budget</td>
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<td>100,000</td>
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<tr>
<td>QIPP08</td>
<td>Lewisham</td>
<td>Cease AMH Programme Management</td>
<td>Complete</td>
<td>PMO</td>
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<td>110,000</td>
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<tr>
<td>QIPP09</td>
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<td>IAPT (15% reduction)</td>
<td>Complete</td>
<td>PMIC</td>
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<tr>
<td>Accounts</td>
<td>Croydon</td>
<td>MHDA Acute OBD reduction</td>
<td>Complete</td>
<td>MHDA</td>
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<td>254,000</td>
<td>254,000</td>
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<tr>
<td>Accounts</td>
<td>Lewisham</td>
<td>Reduction in CAMHS Transformation (Perinatal MH plus extension of Adult (APT))</td>
<td>Complete</td>
<td>PMIC</td>
<td>88,000</td>
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<td>MHDA Acute OBD reduction</td>
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<td>MHDA</td>
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<td>204,000</td>
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<td>Accounts</td>
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<td>MHDA</td>
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<td>362,580</td>
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<td></td>
<td></td>
<td></td>
<td>variance</td>
<td>-1,653,000</td>
<td></td>
</tr>
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</table>
**QIPP Red risks**

- **Southwark Placements.** Value £800K. The plan to move people from high cost placements to lower cost alternatives is off track and will deliver no real savings given the significant growth in overspend on the Southwark placements budget. Work is ongoing to move people to lower cost alternatives.

- **PMIC C&V Services.** Value £445K. This QIPP has been adjusted from £563k to £445k following reconciliation between the PMO and financial forecasting. The aim is to recover the QIPP reduction through marginal rates on additional activity, this will require close monitoring as it requires a significant uplift in activity. Work is underway to measure the performance of the service, however £280K is assessed as at risk, hence the forecast is devalued to £165k (down from 473k previously).

**Upgraded to Red**

- **Lewisham Placements.** Value £365K. The QIPP is has been upgraded from green to red as due to unexpected growth particularly with discharges from Acute wards the 365k savings will not be released. Recovery plans are in place to contain the impact of unexpected growth.

- **Tier 4 Adolescent services.** Value £833K, upgraded from amber to red and will remain red until NHSE confirm any payment. NHSE London have accepted that no proposal was offered for the first 6 months of the year, therefore they have agreed to a mid-year review after Q2 with an expectation of being invoiced for the necessary value. There was an expectation that NHSE would propose alternative QIPP schemes but this has not happened with the commissioners using the repatriation schemes in the CQUIN as the replacement QIPP schemes as referenced elsewhere in this report.

- **Lewisham Community Teams – A&L team.** Value £208K. This has been upgraded from green to red as neither the Psychosis nor the PM&IC CAGs have a workable recovery plan to deliver the required savings without destabilising community services.

**Upgraded to Amber**

- **Increase in cross-boundary flow from Surrey/Sussex and other localities.** Value 600k. This has been upgraded from green to amber. Croydon CCG have confirmed the proposal will not deliver £600k although continue to seek agreement on a reduced value. The Trust and Croydon CCG are completing a statement of differences for escalation to Chief Financial Officers in December to reach an agreed position. The final position will be partially mitigated by the application of the OBD risk share.

**5.2.2 Commissioning for Quality and Innovation (CQUIN) Schemes**

CQUIN is valued at £5.9M and delivery progress is reported to the QSC. The following represents the financial position for CQUIN.

Q2 CQUIN is anticipated to receive all associated payments, however we are currently awaiting formal responses from local commissioners.

The following risks are highlighted for the board’s attention:

- **Flu Vaccination:** The Trust is at 7 weeks into the campaign and we have managed to achieve 37% of vaccination uptake so far. Although this is an impressive increase from previous years’ performances, it is difficult to say whether the increase will continue at similar rate until the end of the campaign and enable to reach the first threshold for payment, which is a minimum of 50% uptake.
• **Physical Health:** Due to delays in developing the information reporting there are some concerns by the Trust leads that the communications with Primary Care audit due in Q3 will be too early to capture the good work that is being done to develop this practice consistently in all Community Teams. Commissioners have been asked to consider for the audit to be done in Q4.

• **Reducing A&E Attendances:** Work continues in collaboration with Acute Trusts and partner agencies to develop joint care planning, however there are still some clear challenges around working on multiple information systems, engagement across the board and cross-boundary flow which will require support from the 4 local commissioners.

• **STP engagement.** There are still no definitive plans on how to achieve the joint targets across the STP, therefore the £1.92M CQUIN award remains at risk. It is anticipated that the withholding of CQUIN under this category may be used to close year end positions at the discretion of the STP, this should become clearer in Q3.

The Trust leads have agreed with the Programme Director that the PMO will review project management support and capability across the CQUIN programme to identify where additional support will be beneficial. It is anticipated that the Physical Health CQUIN will receive additional project management support.
6. Programme Management Office (PMO)

6.1 Cost Improvement Programme (CIP)

The chart above shows the Trust M7 position, showing a forecast variance from plan of £5,269K. A slight improvement on the gap from the previous month. The following narrative covers the recovery planning.

6.1.1 Recovery Planning

The table below shows each CAG and department contribution to the overall CIP position. The PMO is working with all underperforming CAGs and departments to develop emerging schemes to close the gap, however much of the recovery is non-recurrent and while closing the gap this year, will require further recurrent savings next year.

A series of CEO assurance meetings started in October to review the overspend position of each CAG and department recurrent recovery now underway.

The most at variance departments: Acute Care CAG; Estates and Psychosis CAG are already undertaking an overspend review to look for solutions to recover both CIP shortfall and departmental overspend.

The table below has an adjustment for MHOAD of £100k which is an additional non-recurrent lock-in that is not reported in the CIP tracker at figure 5.1.
Bed Pressure
Sustained effort across all Boroughs has seen the overspill position reduced to single figures, but there is still a danger of it creeping back up. Therefore, the net cost estimate of overspill for the year remains at £2.5M and is being treated as an overspill against CAG plans to close beds. Work is continuously ongoing to understand the impact of beds and to determine if it is to be reported as a failure in CIP or an overspill against a reduced bed stock and OBD income; at the moment CIP is being reported as delivered, because beds have been taken out, but the CAG is now overspending because overspill is being used instead. The situation remains high risk.

7. Emergency Planning
The NHSE (London) annual assurance process is currently taking place. SLaM submitted evidence relating to core EPRR standards to NHSE (London) for assessment in November (with the Trust Emergency Planning Manager and Accountable Emergency Officer in attendance). The Board will be updated on the Trust rating.

The Trust is continuing to work with NHSE (London), and the London Ambulance Service (LAS) to create a bespoke Hazardous Material (HazMat) and Chemical Biological Radiological Nuclear and explosives (CBRNe) ‘train the trainer’ course, specifically aimed at Mental Health Trusts. The training is planned to be signed off by LAS in mid-November and then will be rolled out.

In response to the recent ransomware / cyber security incident that affected a substantial proportion of NHS organisations, a SLaM Information and Communication Technology (ICT) ‘task and finish’ group has been set up. This group is to be chaired by the Chief Operating Officer and will have its first meeting in early December 2017 where scope / objectives will be set.

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### CAGs

<table>
<thead>
<tr>
<th>CAGs</th>
<th>Target</th>
<th>Forecast M6</th>
<th>Variance M6</th>
<th>Forecast M7</th>
<th>Variance M7</th>
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<tr>
<td>Psychiatry*</td>
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<td>631</td>
<td>1,713</td>
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<td>BDFT and Addictions</td>
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<td>CAMHS</td>
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<td>-250</td>
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<td>NHSMS &amp; Domains</td>
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<td><strong>Non-CAGs</strong></td>
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<tr>
<td>Estates &amp; Facilities</td>
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<td>1,020</td>
<td>1,170</td>
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<td>Total Services</td>
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<td>Medical &amp; Prof Heads (plus A. R.)</td>
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### Trust wide and gap

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<th>Variance M6</th>
<th>Forecast M7</th>
<th>Variance M7</th>
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<td>SLFT Enhanced income</td>
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<td>Offset: BDFT rates recharge</td>
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<td></td>
<td></td>
</tr>
<tr>
<td>Dividentified: adjustment</td>
<td>-</td>
<td>-564</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Disposal of properties</td>
<td>1,460</td>
<td>1,400</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Total Trustwide and Gap</td>
<td>3,109</td>
<td>3,188</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Overall</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Total CAG</td>
<td>13,198</td>
<td>13,158</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Total non-CAG</td>
<td>8,159</td>
<td>8,142</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Total Trustwide and Gap</td>
<td>5,309</td>
<td>5,266</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Overall total</strong></td>
<td>27,687</td>
<td>19,477</td>
<td>7,210</td>
<td>19,337</td>
<td>7,340</td>
</tr>
</tbody>
</table>
8. Conclusion

The Trust continues to meet the performance-related NHS Improvement Single Oversight Framework indicators with the exception of IAPT recovery. There are a number of risks and associated actions set out in the report.

The contract refresh discussions to confirm 2018/19 (the second year of the 2017/19 contracts) are critical to ensure areas of pressure are addressed including any gap between the contract values, QIPP plans and the finance available for services. Escalation meetings with the Chief Operating Officer have commenced. An escalation meeting is planned with NHS England for their 1718 QIPP programme.

The pressure in the acute inpatient pathway remains significant with particular heat in Lambeth and Lewisham. Actions continue to be based on a whole system approach covering both inpatient and community services to achieve the necessary flow. Additional reporting work is required to present the areas of pressure in community services.

The Trust anticipates receiving the full Q2 CQUIN award although areas of risk as we move into the second half of the year have been highlighted. A PMO review of CQUIN schemes is taking place to identify areas of additional support to achieve the upcoming milestones.

CIP delivery shows a forecast variance of £5.3 million behind plan and this is contributing to the overall Trust position. The PMO is working with all underperforming CAGs and departments to develop emerging schemes to close the gap, however much of the recovery is non-recurrent and while closing the gap this year, will require further recurrent savings next year. A series of CEO assurance meetings started in October to review the overspend position of each CAG and department.

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

<table>
<thead>
<tr>
<th>Abbreviation</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ascom</td>
<td>Alarm / communications system supplied by Ascom UK, a telecommunications company</td>
</tr>
<tr>
<td>CAG</td>
<td>Clinical Academic Group – bringing together clinical services, research and education and training into a single management grouping e.g. Psychosis</td>
</tr>
<tr>
<td>CBT</td>
<td>Cognitive Behavioural Therapy (CBTp is CBT of psychosis)</td>
</tr>
<tr>
<td>CCG</td>
<td>Clinical Commissioning Group – an NHS body responsible for the planning and commissioning of health services for their local area</td>
</tr>
<tr>
<td>CIP</td>
<td>Cost Improvement Programme</td>
</tr>
<tr>
<td>CPA</td>
<td>Care Programme Approach</td>
</tr>
<tr>
<td>CQUIN</td>
<td>Commissioning for Quality and Innovation: A fund where payment is contingent on delivery on quality improvements and meeting milestones agreed with commissioners.</td>
</tr>
<tr>
<td>CYP</td>
<td>Children &amp; Young People</td>
</tr>
<tr>
<td>DBT</td>
<td>Dialectical Behaviour Therapy</td>
</tr>
<tr>
<td>DTOC</td>
<td>Delayed Transfers of Care</td>
</tr>
<tr>
<td>EI</td>
<td>Early Intervention: First Episode Psychosis</td>
</tr>
<tr>
<td>ePJS</td>
<td>Electronic Patient Journey System: Clinical records system</td>
</tr>
<tr>
<td>EPRR</td>
<td>Emergency Preparedness, Resilience and Response</td>
</tr>
<tr>
<td>GSTT</td>
<td>Guys &amp; ST Thomas’ NHS Foundation Trust</td>
</tr>
<tr>
<td>HTT</td>
<td>Home Treatment Team</td>
</tr>
<tr>
<td>IAPT</td>
<td>Improving Access to Psychological Therapies</td>
</tr>
<tr>
<td>JOSC</td>
<td>Joint Overview and Scrutiny Committee</td>
</tr>
<tr>
<td>LSLC</td>
<td>Lambeth, Southwark, Lewisham &amp; Croydon (CCGs)</td>
</tr>
<tr>
<td>MHOA</td>
<td>Mental Health of Older Adults</td>
</tr>
<tr>
<td>MHSDS</td>
<td>Mental Health Services Data Set: National dataset submitted to NHS Digital (formerly known as the Health &amp; Social Care Information Centre)</td>
</tr>
<tr>
<td>NHSE</td>
<td>NHS England</td>
</tr>
<tr>
<td>NHSI</td>
<td>NHS Improvement: the new regulatory body overseeing all NHS providers as well as independent providers that provide NHS funded care</td>
</tr>
<tr>
<td>NHSP</td>
<td>NHS Professionals</td>
</tr>
<tr>
<td>NICE</td>
<td>National Institute for Health and Care Excellence: provides national guidance and advice to improve health and social care</td>
</tr>
<tr>
<td>OAP</td>
<td>Out of Area Placements</td>
</tr>
<tr>
<td>OBD</td>
<td>Occupied Bed Day – is a unit of currency used to measure the use made of a bed (e.g. 1 obd = 1 bed occupied for 1 day by a patient)</td>
</tr>
<tr>
<td>PICU</td>
<td>Psychiatric Intensive Care Unit</td>
</tr>
<tr>
<td>PMF</td>
<td>Performance Management Framework</td>
</tr>
<tr>
<td>PMO</td>
<td>Programme Management Office</td>
</tr>
<tr>
<td>QIA</td>
<td>Quality Impact Assessment</td>
</tr>
<tr>
<td>QIPP</td>
<td>Quality, Innovation, Productivity and Prevention programme is a series of schemes required by the CCGs and developed with SLaM to help enhance services and improve their cost effectiveness</td>
</tr>
<tr>
<td>SEL</td>
<td>South East London</td>
</tr>
<tr>
<td>Acronym</td>
<td>Description</td>
</tr>
<tr>
<td>---------</td>
<td>--------------------------------------------------</td>
</tr>
<tr>
<td>SOF</td>
<td>Single Oversight Framework: NHSI assurance and performance mechanism</td>
</tr>
<tr>
<td>SPC</td>
<td>Statistical Process Control</td>
</tr>
<tr>
<td>STP</td>
<td>Sustainability and Transformation Partnerships</td>
</tr>
<tr>
<td>SWL</td>
<td>South West London</td>
</tr>
<tr>
<td>YTD</td>
<td>Year to Date</td>
</tr>
</tbody>
</table>
Early Intervention in First Episode Psychosis
Completed Pathways (50% target) by Month

Full Risk Screen (CPA Patients) 104
Child Need Risk Screen (CPA Patients) 133
Employment Recording (CPA Patients) 102
Accommodation Recording (CPA Patients) 104

Friends and Family
No. of FFT Responses 1880
FFT Score (%) 100%

Patient Surveys (PEDIC)

Mandatory Training
Trainees 100% 80% 60% 40% 20% 0%
Mandatory Training Tier 1A
Mandatory Training Tier 1B
Clinical Risk
Target

Training Completions (in arrears)
### Introduction

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

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

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

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

### Exception reporting:

IAPT Recovery Rate is reported in the main body of the Chief Operating Officer’s Quality report to the QSC.

### Safe

<table>
<thead>
<tr>
<th>QUESTT incorporates the following Metrics:</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. New or no Ward Manager in post (within last 6 months) ,</td>
</tr>
<tr>
<td>2. Vacancy rate higher than 7% ,</td>
</tr>
<tr>
<td>3. Bank shifts is higher than 6% ,</td>
</tr>
<tr>
<td>4. Sickness absence rate higher than 3% ,</td>
</tr>
<tr>
<td>5. No monthly MPT review of key quality indicators (e.g. peer review or governance team meetings,</td>
</tr>
<tr>
<td>6. Planned annual appraisals not performed</td>
</tr>
<tr>
<td>7. Planned clinical supervision sessions not performed</td>
</tr>
<tr>
<td>8. No formal feedback obtained from patients during the month (e.g. questionnaires or surveys)</td>
</tr>
<tr>
<td>9. 2 or more formal complaints in a month ,</td>
</tr>
<tr>
<td>10. No evidence of resolution to recurring themes,</td>
</tr>
<tr>
<td>11. Unusual demands on service exceeding capacity to deliver ,</td>
</tr>
<tr>
<td>12. Number of hours of enhanced levels of observation exceed 120 ,</td>
</tr>
<tr>
<td>13. Ward/department appears untidy/disrepair ,</td>
</tr>
<tr>
<td>14. No evidence of effective multidisciplinary/multi-professional team working,</td>
</tr>
<tr>
<td>15. On-going investigation or disciplinary investigation</td>
</tr>
</tbody>
</table>

#### Total QUESTT Scores by Ward, September 2017

<table>
<thead>
<tr>
<th>Ward</th>
<th>Score</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ward 1</td>
<td>9</td>
</tr>
<tr>
<td>Ward 2</td>
<td>10</td>
</tr>
<tr>
<td>Ward 3</td>
<td>12</td>
</tr>
<tr>
<td>Ward 4</td>
<td>16</td>
</tr>
<tr>
<td>Ward 5</td>
<td>17</td>
</tr>
<tr>
<td>Ward 6</td>
<td>20</td>
</tr>
<tr>
<td>Ward 7</td>
<td>23</td>
</tr>
</tbody>
</table>

#### Levels:

- **Level 0** (Score = 9 or less)
- **Level 1** (Score = 10 – 16)
- **Level 2** (Score = 17 – 23)
The LEAP system for training and learning was introduced in December. November data was not available due to the transition. For the core skills framework subjects a total of 25 tailored training courses are provided dependent on staff type and including skills refresh. The updated RAG rating has been applied whereby below 70% = Red, 71-84% = Amber, above 85% = Green (except IG which is 95%).
Title
Finance Report As At 31st October 2017

Author
Tim Greenwood & Mark Nelson

Accountable Director
Gus Heafield

Purpose of the paper
The Finance Report provides an update on the financial position of the Trust as at 31st October 2017 (month 7). The summary financial statement and calculation of the Use of Resource rating from the NHSI month 7 submission is attached to the report in Table 2.

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

Executive summary

1) Current Position

At Month 7 ytd, the Trust had made a surplus of £0.4m, a favourable variance of £2m against its month 7 control total. This represents a £2.6m favourable movement in the month, due entirely to the profits made from the sale of 2 properties at Landor Road and Abbevilles.

The underlying position remains as before, driven by a combination of cost pressures, particularly acute overspill, complex placements and unmet CIPs and QIPPs. The acute overspill position has improved with only one bed used in October although maintaining this position will be a considerable challenge.

Additional savings targets were allocated against CAG and infrastructure budgets last month. During October/early November, a series of CEO Challenge meetings took place with each service to go through their positions and clarify what is expected over the remaining 6 months. Further savings schemes are required with the PMO now working with services to help develop and deliver these. Such measures are necessary given the phasing of the plan which moves from a deficit position over the first 6 months to a surplus by the end of the year.

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

The Trust’s cash position remains robust at £51m in October (a £11m favourable variance from plan). This position is driven by unplanned STF funding, capital slippage and property sales and is expected to remain strong throughout the remainder of the year.

The Trust has invested £2.0m of capital expenditure to date (£7.3m below plan) but expects to spend £12m capital (£8m below plan) having rolled forward £6.9m of Douglas Bennett House investment.

The Trust is currently rated by NHSI as a 2 against use of resources (where 1 is best out of a 1-4 range – see Table 2). The rating improved this month due to the impact of the asset sales on the Trust’s I&E margin rating. The Trust retains good ratings against liquidity (cash position) and being below the NHSI agency cost ceiling.
2) Key Risks/Drivers

- The use of acute overspill beds has resulted in a cost pressure, after application of risk shares, of £2.4m after 7 months. Through the introduction of a range of measures, overspill numbers have fallen to a new low in October of just 1 bed. At the same time CCG contracted bed numbers continue to fall in line with QIPP plans. The target trajectory aims to contain the Trust's financial exposure to c£2.5m by maintaining overspill in line with planned funding.

- In order to deliver on its control total for 17/18, the Trust has set a savings target of £27m (16/17 £29.2m). As at month 7, the Trust had generated CIP savings of £13.5m. Due to the month 7 property disposals, the Trust remains ahead of its NHSI CIP plan by £1.7m. However, forecast CIP savings are not expected to keep pace with a savings target that is set to accelerate over the remaining months (with 66% of savings due over the 2nd half of the year). Without additional schemes and mitigations the forecast shortfall from the original £27m target is £5.3m (an 81% achievement). The Trust is developing in year plans to close its forecast CIP gap with the Trust’s PMO ensuring that any slippage is arrested/minimised and that substitute schemes are developed. In addition further gains from property disposals are expected to yield additional savings by year end. Further details on the Trust’s CIP performance can be found in Table 3.

- Southwark placements remain a concern and are £1.1m overspent (before application of risk shares and the 17/18 QIPP), an increase in the adverse variance of £230k in the month. This budget is also subject to a CCG QIPP of £800k. The plans to address both the QIPP and current underlying overspend are proving a considerable challenge despite an agreed recovery plan and monthly meetings with the Local Authority and CCG to review progress. The Trust is now forecasting an overall deficit of £1.9m after taking account of QIPP and risk shares. Lewisham placements (where a QIPP of £365k has been applied) are also overspending whilst Lambeth placements, under the Integrated Personalised Support Alliance, remain in balance.

- Agency usage over the first 7 months is c21% below the NHSI ceiling – a much improved position compared to 2016/17. However within this total figure a separate target has been provided by NHSI for medical agency. The Trust is currently exceeding this target by 15%. It is important for the Trust to target high usage areas such as this not only to meet NHSI targets but agency reductions form part of the CIP programme. Assuming a 20% premium, the Trust has already spent around £1.6m more than employing equivalent permanent staff.

- In addition to external overspill, the cost of running our own beds remains a concern with nursing costs £0.9m ytd above funded establishment. Just 5 wards in the Trust make up 96% of this figure including Lambeth and Lewisham Triage wards where slippage on their conversion to acute wards has meant that the staffing budgets no longer match the cost of running the wards. The Lambeth Triage ward has now converted and its costs are expected to move in line with budget. The other standout wards are 2 of the PICUs (Johnson & Eden) and Heather Close. The Johnson PICU Unit is subject to a QI special observations project whilst Heather Close forms part of the Psychosis recovery plan.

- CCG and NHSE QIPP schemes total £10m in 17/18.

The CCG schemes are aimed primarily at reductions in Adult/MHOA acute occupied bed days (obds) and complex placements and changes to community services including IAPT. 3 of the CCGs are above their contracted adult bed numbers and this is impacting on the delivery of their QIPP schemes, particularly in Lambeth where no acute bed QIPP is currently being realised.

As indicated previously there are also high risks attached to the Southwark placements and placement team QIPP of £800k where, despite a milestone plan being worked through with the CCG, the forecast overspend requires significant savings to be made beyond just the QIPP reduction.
In Croydon a proposed QIPP of £600k involving recharging other CCGs for their use of beds has been disputed following a review of audit data and is expected to fall significantly. A revised proposal has been sent to SLaM and is being considered.

The NHSE schemes also involve a reduction in beds across forensic, CAMHS and Eating Disorder. The forensic bed reduction is working to plan but the Trust is continuing to meet with NHSE to ensure there is clarity about the £1.1m of savings plans in CAMHS and Eating Disorders. To date no agreement has been reached as to how these QIPPs will be delivered and it is therefore the intention of the Trust to invoice NHSE for the QIPP that has been removed.

- Last year the Trust performed well against its cost and volume income targets (higher risk income that relates directly to increases/decreases in activity). However the performance overall, masked areas where income was not on plan. Some of these areas have continued to underperform going into 2017/18 and are now driving the bottom line deficit of £0.5m at month 7. These areas include Heather Close and Neuro Psychiatry, Eating Disorder and Affective Disorder Outpatients and several CAMHS outpatient services.

3) Forecast

At Month 7, the Trust is still forecasting to meet its NHSI surplus control total of £2.2m (including STF). This is seen as challenging but achievable. Following this month’s asset sales, a review of remaining restructuring costs and improvements in both CAG and infrastructure forecasts the Trust has identified financial risks totalling £6.5m by year end (£10.5m at month 6). The principal drivers behind this figure are –

- Red rated CIPs
- Delivery of QIPPs
- Demand pressures on beds and placements
- Other net pressures

Following the CEO Challenge meetings, plans are being implemented to mitigate these risks utilising the Trust PMO Function, including –

- Development /implementation of additional savings plans in line with updated CIP targets
- Significant engagement with our local CCGs regarding the continued use of overspill beds
- Reaching agreement with NHSE over the funding of QIPP targets
- Development and application of QI programmes
- Further collaborative savings through our South London Mental Health and Community Partnership with Oxleas and South West London and St Georges Trusts and the STPs
- Non-recurrent savings measures such as further asset sales, balance sheet analysis review and examination of discretionary expenditure.

Although we are forecasting that we will hit the control total, there are still significant risks in delivery as detailed in the report and to do so we are reliant on non-recurrent savings in totalling some £10m. We are focussing on increasing the delivery of recurrent schemes this year to reduce the reliance on non-recurrent items. This will mean that our target for recurrent savings in 2018/19 will need to increase to cover the extent of any non-recurrent elements this year (so from £8m to £18m based on our current planning) and subject to the outcome of any commissioning discussions around CIP, QIPP and CQUIN targets.
### 1) Financial Summary

#### Service Analysis

<table>
<thead>
<tr>
<th>Area</th>
<th>Full Year Live Budgets (£)</th>
<th>Monthly Figures</th>
<th>Year to Date Figures</th>
<th>Variance Last Month (£)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Current Mth Actual (£)</td>
<td>Variance From Live Budgets (£)</td>
<td>Year To Date Actual (£)</td>
<td>Variance From Live Budgets (£)</td>
</tr>
<tr>
<td>01. Psychosis</td>
<td>52,277,400</td>
<td>4,926,000</td>
<td>573,500</td>
<td>32,388,400</td>
</tr>
<tr>
<td>02. Acute Care Pathway</td>
<td>44,527,200</td>
<td>4,099,400</td>
<td>393,300</td>
<td>28,779,500</td>
</tr>
<tr>
<td>03. P Med &amp; Integrated Care</td>
<td>(553,600)</td>
<td>(29,500)</td>
<td>30,100</td>
<td>(305,700)</td>
</tr>
<tr>
<td>04. Behavioural And Dev. Psych</td>
<td>(370,700)</td>
<td>(140,900)</td>
<td>(88,500)</td>
<td>(586,300)</td>
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<tr>
<td>05. Child &amp; Adolescent Service</td>
<td>132,800</td>
<td>22,900</td>
<td>20,900</td>
<td>386,100</td>
</tr>
<tr>
<td>06. MHOA And Dementia</td>
<td>316,100</td>
<td>0</td>
<td>31,900</td>
<td>92,800</td>
</tr>
<tr>
<td>09. Infrastructure Directorates</td>
<td>53,927,600</td>
<td>4,865,200</td>
<td>529,500</td>
<td>33,697,500</td>
</tr>
<tr>
<td>10. Corporate Income</td>
<td>(102,393,600)</td>
<td>(8,855,400)</td>
<td>(217,700)</td>
<td>(59,905,300)</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>49,368,400</strong></td>
<td><strong>5,072,900</strong></td>
<td><strong>1,294,100</strong></td>
<td><strong>36,072,200</strong></td>
</tr>
<tr>
<td><strong>Operational Deficit</strong></td>
<td><strong>(69,745,984)</strong></td>
<td>(5,961,900)</td>
<td>(148,969)</td>
<td>(40,706,300)</td>
</tr>
<tr>
<td>11. Corporate Other</td>
<td>(3,890,816)</td>
<td>0</td>
<td>648,469</td>
<td>0</td>
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<tr>
<td><strong>Other包括/Unallocated CIPs</strong></td>
<td>1,500,000</td>
<td>0</td>
<td>1,950,300</td>
<td>0</td>
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<tr>
<td><strong>Corporate Other</strong></td>
<td>(69,270,200)</td>
<td>(5,961,900)</td>
<td>(54,300)</td>
<td>(2,234,700)</td>
</tr>
<tr>
<td><strong>EBITDA</strong></td>
<td><strong>(19,901,800)</strong></td>
<td>(889,000)</td>
<td><strong>1,239,800</strong></td>
<td><strong>(4,634,100)</strong></td>
</tr>
</tbody>
</table>

#### Monthly Figures

<table>
<thead>
<tr>
<th>Area</th>
<th>2017/18 Mth 2 Variance £000</th>
<th>2017/18 Mth 3 Variance £000</th>
<th>2017/18 Mth 4 Variance £000</th>
<th>2017/18 Mth 5 Variance £000</th>
<th>2017/18 Mth 6 Variance £000</th>
<th>2017/18 Mth 7 Variance £000</th>
<th>2017/18 Total Variance £000</th>
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<tr>
<td>CAGs</td>
<td>708</td>
<td>831</td>
<td>322</td>
<td>895</td>
<td>(151)</td>
<td>888</td>
<td>4,545</td>
</tr>
<tr>
<td>Infrastructure Directorates</td>
<td>319</td>
<td>(80)</td>
<td>285</td>
<td>467</td>
<td>360</td>
<td>622</td>
<td>2,068</td>
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<tr>
<td>Corp Income</td>
<td>61</td>
<td>(220)</td>
<td>(322)</td>
<td>151</td>
<td>107</td>
<td>(217)</td>
<td>(512)</td>
</tr>
<tr>
<td>Other including provisions released &amp; unidentified CIPs</td>
<td>104</td>
<td>31</td>
<td>55</td>
<td>194</td>
<td>(811)</td>
<td>470</td>
<td>591</td>
</tr>
<tr>
<td>Use of Reserves</td>
<td>(317)</td>
<td>(449)</td>
<td>10</td>
<td>(1,423)</td>
<td>725</td>
<td>(523)</td>
<td>(2,825)</td>
</tr>
<tr>
<td><strong>Total EBITDA</strong></td>
<td>875</td>
<td>113</td>
<td>350</td>
<td>283</td>
<td>230</td>
<td>1,240</td>
<td>3,867</td>
</tr>
</tbody>
</table>

#### Key Cost Drivers (unmitigated by alternative income, risk shares etc.)

<table>
<thead>
<tr>
<th>Area</th>
<th>2017/18 Mth 2 Variance £000</th>
<th>2017/18 Mth 3 Variance £000</th>
<th>2017/18 Mth 4 Variance £000</th>
<th>2017/18 Mth 5 Variance £000</th>
<th>2017/18 Mth 6 Variance £000</th>
<th>2017/18 Mth 7 Variance £000</th>
<th>2017/18 Total Variance £000</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ward Nursing*</td>
<td>51</td>
<td>270</td>
<td>203</td>
<td>117</td>
<td>132</td>
<td>57</td>
<td>939</td>
</tr>
<tr>
<td>Agency Premium @ 20%</td>
<td>209</td>
<td>223</td>
<td>281</td>
<td>270</td>
<td>167</td>
<td>218</td>
<td>1,619</td>
</tr>
<tr>
<td>Acute Overspill***</td>
<td>509</td>
<td>578</td>
<td>668</td>
<td>124</td>
<td>(75)</td>
<td>147</td>
<td>2,892</td>
</tr>
<tr>
<td>Unmet CIPs**</td>
<td>(53)</td>
<td>(918)</td>
<td>381</td>
<td>(57)</td>
<td>89</td>
<td>(1,147)</td>
<td>(1,651)</td>
</tr>
<tr>
<td>Placements***</td>
<td>173</td>
<td>199</td>
<td>339</td>
<td>162</td>
<td>216</td>
<td>230</td>
<td>1,469</td>
</tr>
<tr>
<td>CPC/C&amp;V Income</td>
<td>147</td>
<td>95</td>
<td>(50)</td>
<td>235</td>
<td>(39)</td>
<td>(42)</td>
<td>485</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td>1,036</td>
<td>447</td>
<td>1,822</td>
<td>851</td>
<td>490</td>
<td>(537)</td>
<td>5,753</td>
</tr>
</tbody>
</table>

* includes safer staffing funding **see Section 3*** before application of risk shares

Performance against the main cost drivers is detailed below –
• **Acute/PICU Overspill**

Overall 1 overspill bed was used by the Trust in October, a decrease of 8 compared to the previous month. The use of overspill beds has resulted in a cost pressure, after application of risk shares, of £2.4m after 7 months. The forecast £2.5m deficit caused by overspill assumes that the Trust will now use a monthly average of 4.2 overspill beds over the remainder of the year compared to an average of 24 beds over the first 7 months. This is a tight position to maintain but overspill has fallen with intensive work being undertaken under the QI initiative and a new policy to no longer fund overspill above CCG funded levels.

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

---

**Total Acute/PICU Beds Used By LSLC CCGs Since 1/4/16**

![Graph showing bed usage by LSLC CCGs from 4/1/16]  
*Number of Beds vs. Months*

**Total LSLC CCG Acute/PICU Beds Used Since 1/4/16**

![Graph showing bed usage by LSLC CCGs from 4/1/16]  
*Number of Beds vs. Months*

---

Overall local CCG bed usage fell by 2 in October whilst contracted bed numbers also decreased by 2. There are +10% variances from contracted activity in both Lambeth and Lewisham. The main outlier continues to be Lambeth where bed numbers are 25% above their ytd contracted level of activity (assuming 95% occupancy). Bed use has been falling in Lambeth since June but was still around 17% above contract during October. The second graph above indicates the potential disparity between CCG contracted beds which are falling and the Trust’s bed stock and actual use of beds which are now similar. The Trust is making better use of its beds with activity more aligned with bed stock. If the Trust could eliminate overspill and keep to its bed stock numbers, additional net income could be generated through the CCG risk share arrangements.
• **Use of Agency Staff**

NHSI have set a ceiling to spend no more than £17.4m on all agency staff. In 2016/17 the Trust spent £22.6m on agency. Agency spend overall is still below the ceiling after 7 months although the target is phased to decrease over the remainder of the year. The spend in October of £1.3m was below the ytd monthly average. The forecast below which is based on a prudent, simple extrapolation of the year to date position shows that the Trust must continue with its work to reduce agency if it is to keep within the NHSI ceiling. A number of initiatives are in place to bring about a reduction targeting band 5 nurses, CPNs, care support workers, nurse team leaders, A&C and medical.

<table>
<thead>
<tr>
<th></th>
<th>Plan Beds @ 95%</th>
<th>Actual Beds</th>
<th>Variance Beds</th>
<th>Variance %</th>
<th>Total Beds</th>
<th>Last Mth Beds</th>
</tr>
</thead>
<tbody>
<tr>
<td>Lambeth</td>
<td>79</td>
<td>99</td>
<td>20</td>
<td>25.6%</td>
<td>20</td>
<td>21</td>
</tr>
<tr>
<td>Southwark</td>
<td>72</td>
<td>77</td>
<td>5</td>
<td>6.5%</td>
<td>2</td>
<td>5</td>
</tr>
<tr>
<td>Lewisham</td>
<td>63</td>
<td>73</td>
<td>10</td>
<td>15.2%</td>
<td>9</td>
<td>9</td>
</tr>
<tr>
<td>Croydon</td>
<td>83</td>
<td>82</td>
<td>-1</td>
<td>-1.3%</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>297</strong></td>
<td><strong>330</strong></td>
<td><strong>33</strong></td>
<td><strong>11.2%</strong></td>
<td><strong>35</strong></td>
<td></td>
</tr>
</tbody>
</table>

Included in the above are medical agency which have their own NHSI target of £2.3m based on 2016/17 outturn less £430k. Based on current expenditure this target will not be met and is forecast to be at £3.2m (39% above target).

• **Ward/Unit Nursing Costs**

At month 7 ward nursing costs overspent by £57k (£939k ytd). This is below the 2016/17 average but still +3% above budgets that have been set at safer staffing levels. The majority of the overspends occurred in the ACP CAG including the 2 remaining Triage wards (£454k overspent ytd) where plans to convert them to acute wards have been delayed and 2 of the PICUs which taken together are 18% over budget. The Lambeth Triage ward has now converted with new staffing rotas in place from October.
• **Cost per Case/Cost and Volume Income**

The overall position continues to underperform, particularly in 3 of the CAGs –

- **Psychosis** – Heather Close is now £136k below target levels following an increase in the income target and a continuing number of unused cost per case beds. It is also £92k over on expenditure budgets. In addition the Psychosis Unit is £228k below income target (although offset by a pay underspend) whilst the PICUP service has not been able to meet its increased 17/18 income target. Recovery plans are being developed for both Heather Close and PICUP.

- **Psych Med & Integrated Care** – are not meeting activity/income targets in several outpatient services particularly neuro psychiatry (£154k ytd), eating disorders (£137k ytd) and affective disorders (£76k ytd). All have savings plans under review. It is a similar position on eating disorder inpatient services (£171k ytd) where an NHSE QIPP has been applied but where there is currently an insufficient increase in compensating income or reduction in cost. The Trust is in discussions with NHSE regarding the QIPP and how it is to be realised.

- **CAMHS** – the underperformance currently relates to outpatient services where several of the teams are currently off target. This is expected to improve but there remain outstanding issues with NHSE regarding the £0.8m QIPP that has been applied to the Kent inpatient contract with no agreement as to how this saving is to be achieved. Again the Trust is in discussions about recovering the reduction in funding.

<table>
<thead>
<tr>
<th>CAG</th>
<th>Income Target At Month 7 £’000</th>
<th>Actual invoiced At Month 7 £’000</th>
<th>Surplus/ Deficit(-) At Month 7 £’000</th>
<th>Surplus/ Deficit(-) At Month 6 £’000</th>
</tr>
</thead>
<tbody>
<tr>
<td>Psychosis</td>
<td>4,650</td>
<td>4,316</td>
<td>334</td>
<td>293</td>
</tr>
<tr>
<td>Behavioural &amp; Developmental</td>
<td>13,245</td>
<td>13,914</td>
<td>(669)</td>
<td>(515)</td>
</tr>
<tr>
<td>Psych Med &amp; Integrated Care</td>
<td>11,962</td>
<td>11,544</td>
<td>417</td>
<td>394</td>
</tr>
<tr>
<td>CAMHS</td>
<td>15,900</td>
<td>15,470</td>
<td>430</td>
<td>379</td>
</tr>
<tr>
<td>MHOA</td>
<td>35</td>
<td>62</td>
<td>(27)</td>
<td>(23)</td>
</tr>
<tr>
<td><strong>TOTAL</strong></td>
<td><strong>45,792</strong></td>
<td><strong>45,307</strong></td>
<td><strong>485</strong></td>
<td><strong>527</strong></td>
</tr>
</tbody>
</table>

• **Complex Placements**

Lambeth placements remain within budget. However Lewisham are overspending (£222k ytd) where a £365k QIPP was applied at the start of the year. In Southwark, placements activity continues to overperform on both the CCG and Local Authority elements of the budget. The ytd overspend of £1.3m is split between the CCG (£0.7m) and the local authority (£0.6m) but this excludes an £800k CCG QIPP for which a recovery milestone plan is in operation but which has yet to impact on the bottom line. The local authority overspend is subject to a 100% risk share but –

- this is accessed via the CCG contract and requires agreement from the local authority to pay the CCG. Issues are being raised by the local authority regarding the timeliness of reviews and these will need to be addressed to ensure full payment is made
- the CCG and local authority are still examining how each individual placement is funded i.e. are they a CCG funded, a local authority funded or a jointly funded placement and if so what % split is applied. Until these issues are resolved there remains a risk that retrospective shifting of responsibility/liability will impact on the Trust’s risk share values with both the Local Authority and the CCG
- The QIPP referred to above applies to CCG funded placements only and so any Local Authority savings resulting from the QIPP plan are likely to impact on the risk share rather than the CCG QIPP target

The CCG are undertaking monthly reviews with the Local Authority and Trust to review progress, monitor action plans, and improve processes and quality of information. However the position does not
appear to be improving and it is now very unlikely that the financial targets will be met. The forecast overspend on the CCG element of placements is now estimated at £1.9m (including the £800k QIPP)

Glossary

<table>
<thead>
<tr>
<th>Acronym</th>
<th>Definition</th>
</tr>
</thead>
<tbody>
<tr>
<td>AMH</td>
<td>Adult Mental Health – used in this report to cover a programme of investment in community schemes that aim to reduce the usage of acute/ triage beds in the Trust</td>
</tr>
<tr>
<td>CAG</td>
<td>Clinical Academic Group – bring together clinical services, research and education and training into a single management grouping e.g. Psychosis</td>
</tr>
<tr>
<td>CCG</td>
<td>Clinical Commissioning Group – an NHS body responsible for the planning and commissioning of health services for their local area</td>
</tr>
<tr>
<td>CIPs</td>
<td>Cost Improvement Programme</td>
</tr>
<tr>
<td>CPC/C&amp;V</td>
<td>Cost per Case and Cost and Volume income varies depending upon the amount of clinical activity being undertaken</td>
</tr>
<tr>
<td>EBITDA</td>
<td>Earnings before interest, tax, depreciation and amortisation is an accounting measure used as a proxy for an organisation’s current operating profitability</td>
</tr>
<tr>
<td>ICT</td>
<td>Information and Communications Technology</td>
</tr>
<tr>
<td>MHOA</td>
<td>Mental Health of Older Adults</td>
</tr>
<tr>
<td>NCA</td>
<td>Non Contracted Activity - a patient treated by SLaM where no contract exists between the Trust and the Commissioner (e.g. a Lewisham resident who has a Bromley GP will not be charged against the Lewisham contract but will be invoiced as an NCA to Bromley CCG)</td>
</tr>
<tr>
<td>NHSI</td>
<td>NHS Improvement – the new regulatory body overseeing all NHS providers as well as independent providers that provide NHS funded care</td>
</tr>
<tr>
<td>OBD</td>
<td>Occupied Bed Day – is a unit of currency used to measure the use made of a bed (e.g. 1 obd = 1 bed occupied for 1 day by a patient)</td>
</tr>
<tr>
<td>PICU</td>
<td>Psychiatric Intensive Care Unit - provide mental health care and treatment for people whose acute distress, absconding risk and suicidal or challenging behaviour needs a secure environment beyond that which can normally be provided on an open psychiatric ward</td>
</tr>
<tr>
<td>PoS</td>
<td>Place of Safety – under section 136 of the Mental Health Act, the police have the power to take an apparently mentally disordered person who is in a public place and is apparently a danger to himself or to other people, to a “place of safety” where they may be assessed by a doctor</td>
</tr>
<tr>
<td>QIPP</td>
<td>The Quality, Innovation, Productivity and Prevention programme is a series of schemes required by the CCGs and developed with SLaM to help reduce the cost of services to the CCG</td>
</tr>
<tr>
<td>STF</td>
<td>Sustainability &amp; Transformation Fund that is intended to support providers to move to a sustainable financial footing</td>
</tr>
<tr>
<td>Triage</td>
<td>Triage ward – used to admit patients for a short period of time where their needs are assessed before being either discharged to the care of community teams or transferred to an acute ward</td>
</tr>
<tr>
<td>WTE</td>
<td>Whole Time Equivalent – is a concept used to convert the hours worked by several part-time employees into the hours worked by full-time employees e.g. 1 wte = 1 full time employee</td>
</tr>
<tr>
<td>YTD</td>
<td>Year To Date</td>
</tr>
</tbody>
</table>
4) The Trust’s cash position remains robust at £51m in October (an £11m favourable variance from plan). This position is driven by £0.4m £-2m

Summary

Performance v CIP - £1.7m above NHSI Plan - 14% > target (inc profits on sale of assets & lock-ins)

1) At Month 7 ytd the Trust made a surplus of £0.4m, a favourable variance of £2m against the NHSI control total

1.38 2.29 2.20 3.11

SLaM - Financial Overview as at 31st October 2017 (Month 7)

Income and Expenditure

<table>
<thead>
<tr>
<th>YTD</th>
<th>YTD Plan</th>
<th>Forecast/actual</th>
<th>FY Plan</th>
</tr>
</thead>
<tbody>
<tr>
<td>EBITDA</td>
<td>£4.5m</td>
<td>£8.5m</td>
<td>£13.3m</td>
</tr>
<tr>
<td>I&amp;E (deficit) surplus</td>
<td>£0.4m</td>
<td>£0.2m</td>
<td>£0.3m</td>
</tr>
<tr>
<td>Debt service cover</td>
<td>2.1%</td>
<td>3.0%</td>
<td>3.5%</td>
</tr>
</tbody>
</table>

Debt service cover x

Cumulative EBITDA

New NHSI I&E control total surplus (deficit)

Cost Improvement Programme

Working Capital

Financial Position

Use of Resources Risk Rating

Key Financial Drivers

- Performance v CIP - £1.7m above NHSI Plan - 14% > target (inc profits on sale of assets & lock-ins)

- Ward Nursing - £0.34m overspent

- Acute Overspill - £1.5m overspent excluding impact of risk share

- Complex/Non Secure Placements - £1.5m overspent excluding impact of risk shares & Swk QIPP

- Cost per Case/Cost & Volume - £0.5m ytd v plan

Other Metrics

- Forecast FMR less than 2 (relief 12 months)

- Better payment practice code (non-NHS by value)

- Cash at bank and in hand

- Capital spend against plan

- Agency ceiling target £17.4m

Commentary

1) At Month 7 ytd the Trust made a surplus of £0.4m, a favourable variance of £2m against the NHSI control total

2) The surplus represents a £2.6m favourable movement in the month, due entirely to the profits made from the sale of 2 properties. The underlying position remains as before, driven by a combination of cost pressures, particularly acute overspill, complex placements and unmet CIPs and QIPPs

3) During October/early November, a series of CEO Challenge meetings took place with each service to go through their positions and clarify what is expected over the remaining 6 months.

4) The Trust is currently rated by NHSI as a 2 against use of resources (where 1 is best out of a 1-4 range). The rating improved this month due to the impact of the asset sales on the Trust’s I&E margin rating. The Trust retains good ratings against liquidity (cash position) and being below the NHSI agency cost ceiling

5) The Trust has generated CIP savings of £13.5m. Due to the month 7 property disposals the Trust remains ahead of its NHSI CIP plan by £1.7m. However, forecast CIPs are not expected to keep pace with a savings target that is set to accelerate over the remaining months (with 66% of savings due over the 2nd half of the year). Without additional schemes and mitigations the forecast shortfall from the original £27m target is £5.3m (an 81% achievement). The Trust is developing in year plans to close its forecast CIP gap with the Trust’s PMO ensuring that any slips page is arrested/minimised and that substitute schemes are developed. In addition further gains from property disposals are expected to yield additional savings by year end
### Table 1

#### Monthly Figures Year to Date Figures

<table>
<thead>
<tr>
<th>Service Analysis</th>
<th>Full Year Live Budgets (£)</th>
<th>Current Month Variance From Live Budgets (£)</th>
<th>Year To Date Variance From Live Budgets (£)</th>
<th>Variance Last Month (£)</th>
</tr>
</thead>
<tbody>
<tr>
<td>01. Psychosis</td>
<td>52,277,400</td>
<td>6,426,000</td>
<td>573,500</td>
<td>2,172,700</td>
</tr>
<tr>
<td>02. Acute Care Pathway</td>
<td>44,527,200</td>
<td>4,099,400</td>
<td>393,300</td>
<td>2,813,600</td>
</tr>
<tr>
<td>03. P Med &amp; Integrated Care</td>
<td>(533,600)</td>
<td>(29,500)</td>
<td>30,100</td>
<td>(1,179,200)</td>
</tr>
<tr>
<td>04. Behavioural And Dev. Psych</td>
<td>(370,700)</td>
<td>(140,900)</td>
<td>(88,500)</td>
<td>(404,100)</td>
</tr>
<tr>
<td>05. Child &amp; Adolescent Services</td>
<td>132,800</td>
<td>22,380</td>
<td>20,380</td>
<td>411,100</td>
</tr>
<tr>
<td>06. MHCA &amp; Dentistry</td>
<td>316,100</td>
<td>(44,400)</td>
<td>(72,700)</td>
<td>(110,900)</td>
</tr>
<tr>
<td>08. Addictions</td>
<td>0</td>
<td>31,900</td>
<td>31,900</td>
<td>60,900</td>
</tr>
<tr>
<td>09. Infrastructure Directories</td>
<td>53,927,600</td>
<td>4,665,200</td>
<td>259,600</td>
<td>1,779,700</td>
</tr>
<tr>
<td>10. Corporate Income</td>
<td>(110,369,400)</td>
<td>(2,620,800)</td>
<td>(217,700)</td>
<td>(512,700)</td>
</tr>
<tr>
<td>11. Corporate Other</td>
<td>40,364,400</td>
<td>6,772,900</td>
<td>2,294,100</td>
<td>4,267,500</td>
</tr>
<tr>
<td>12. Unidentified/Unallocated CIPs</td>
<td>40,270,200</td>
<td>(5,861,000)</td>
<td>(34,320)</td>
<td>(2,374,500)</td>
</tr>
<tr>
<td>13. Estates &amp; Facilities</td>
<td>(69,174,900)</td>
<td>(1,618,000)</td>
<td>(1,440,000)</td>
<td>(2,000,000)</td>
</tr>
<tr>
<td>15. Chief Operating Officer</td>
<td>3,698,200</td>
<td>(68,700)</td>
<td>(94,700)</td>
<td>(25,400)</td>
</tr>
<tr>
<td>16. R&amp;D</td>
<td>(5,918,900)</td>
<td>(483,000)</td>
<td>(10,700)</td>
<td>(42,900)</td>
</tr>
<tr>
<td>17. Infrastructure Directorates</td>
<td>53,927,600</td>
<td>4,665,200</td>
<td>259,600</td>
<td>1,779,700</td>
</tr>
<tr>
<td>18. Corporate Other</td>
<td>(73,636,800)</td>
<td>(5,961,900)</td>
<td>(40,706,300)</td>
<td>(590,600)</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>2,979,600</strong></td>
<td><strong>3,298,000</strong></td>
<td><strong>1,991,400</strong></td>
<td><strong>2,545,500</strong></td>
</tr>
</tbody>
</table>

**Notes Re Mth 7**

- New 16/17 CIPs, unfunded cost of JW Hse, capital planning pay costs, rented accommodation income shortfall, disputed NHS Properties rentals,16/17 car parking CIP, security costs of Douglas Bennett House and main costs at BRH.
- New CIP target.
- Unfunded costs of ending the Aramark contract plus additional costs of new contract that can't be recovered from CAGs as budget (will result in a reduction in the CAG overspend instead).
- New Chief Operating Officer CIP.
- New CIP target.
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- New CIP target.
- New CIP target.
### Table 2

#### NHSI Summary For South London & Maudsley NHS Foundation Trust

1. **Key data**

<table>
<thead>
<tr>
<th></th>
<th>PLAN YTD</th>
<th>ACT YTD</th>
<th>VAR YTD</th>
<th>PLAN CY</th>
<th>FOT CY</th>
<th>VAR CY</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>£’000</td>
<td>£’000</td>
<td>£’000</td>
<td>£’000</td>
<td>£’000</td>
<td>£’000</td>
</tr>
<tr>
<td>Performance against control total</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Surplus/(deficit) before impairments and transfers</td>
<td>(2,014)</td>
<td>396</td>
<td>2,410</td>
<td>1,828</td>
<td>2,297</td>
<td>469</td>
</tr>
<tr>
<td>Less sustainability &amp; transformation fund (STF)</td>
<td>(1,713)</td>
<td>278</td>
<td>1,991</td>
<td>2,344</td>
<td>2,389</td>
<td>45</td>
</tr>
<tr>
<td>Control total</td>
<td>(1,762)</td>
<td>1,968</td>
<td>0</td>
<td>2,262</td>
<td>2,262</td>
<td>0</td>
</tr>
<tr>
<td>Performance against control total excluding STF</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Adjusted financial performance surplus/(deficit) including STF</td>
<td>(1,713)</td>
<td>278</td>
<td>1,991</td>
<td>2,344</td>
<td>2,389</td>
<td>45</td>
</tr>
<tr>
<td>Control total excluding STF</td>
<td>(2,780)</td>
<td>(2,780)</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Performance against control total excluding STF</td>
<td>50</td>
<td>3,041</td>
<td>1,991</td>
<td>82</td>
<td>127</td>
<td>45</td>
</tr>
</tbody>
</table>

2. **Use of resources risk rating summary**

<table>
<thead>
<tr>
<th></th>
<th>PLAN YTD</th>
<th>ACT YTD</th>
<th>VAR YTD</th>
<th>PLAN CY</th>
<th>FOT CY</th>
<th>VAR CY</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>31/10/2017</td>
<td>31/10/2017</td>
<td>31/10/2017</td>
<td>31/03/2018</td>
<td>31/03/2018</td>
<td>31/03/2018</td>
</tr>
<tr>
<td></td>
<td>£’000</td>
<td>£’000</td>
<td>£’000</td>
<td>£’000</td>
<td>£’000</td>
<td>£’000</td>
</tr>
<tr>
<td>Capital service cover rating</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Liquidity rating</td>
<td>2</td>
<td>1</td>
<td>1</td>
<td>2</td>
<td>1</td>
<td>1</td>
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<tr>
<td>I&amp;E margin rating</td>
<td>3</td>
<td>2</td>
<td>2</td>
<td>2</td>
<td>2</td>
<td>2</td>
</tr>
<tr>
<td>Agency rating</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>Risk rating after overrides</td>
<td>2</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
</tr>
</tbody>
</table>
Table 3  Summary CIP Performance

<table>
<thead>
<tr>
<th>TRUST CIP POSITION</th>
<th>RAG Ratings &amp; Risks</th>
<th>Income/Cost Type</th>
<th>FY Plan 17/18</th>
<th>FY Forecast 17/18</th>
<th>FY Variance 17/18</th>
</tr>
</thead>
<tbody>
<tr>
<td>FYP E</td>
<td></td>
<td>Pay</td>
<td>12,276</td>
<td>11,638</td>
<td>638</td>
</tr>
<tr>
<td>CYP E</td>
<td>27,022</td>
<td>Non Pay</td>
<td>9,581</td>
<td>8,156</td>
<td>1,425</td>
</tr>
<tr>
<td>Forecast Outturn</td>
<td>21,758</td>
<td>Income</td>
<td>3,106</td>
<td>4,021</td>
<td>915</td>
</tr>
<tr>
<td>YTD Plan</td>
<td>11,829</td>
<td>Total</td>
<td>27,022</td>
<td>21,758</td>
<td>5,264</td>
</tr>
<tr>
<td>YTD Actuals</td>
<td>13,480</td>
<td>Recurrent</td>
<td>24,008</td>
<td>15,634</td>
<td>8,374</td>
</tr>
<tr>
<td>YTD Variance</td>
<td>1,651</td>
<td>Non Recurrent</td>
<td>3,014</td>
<td>6,124</td>
<td>3,110</td>
</tr>
<tr>
<td>YTD Achieved %</td>
<td>114%</td>
<td>£'000s</td>
<td>£'000s</td>
<td>£'000s</td>
<td>£'000s</td>
</tr>
</tbody>
</table>

Financial Position M7

<table>
<thead>
<tr>
<th>FYP E</th>
<th>CYP E</th>
<th>Forecast Outturn</th>
<th>YTD Plan</th>
<th>YTD Actuals</th>
<th>YTD Variance</th>
<th>YTD Achieved %</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>27,022</td>
<td>21,758</td>
<td>11,829</td>
<td>13,480</td>
<td>1,651</td>
<td>114%</td>
</tr>
</tbody>
</table>

Summary of Progress

The position at Month 7 is £1.1m ahead of the in month target of £2.5m and £5.6m ahead of the YTD target of £11.8m.

The main driver behind the YTD position are the gains on disposal of property of £2.5m which was recognised in M7. ACP YTD undershielding is £1.2m YTD as a result of the impact of acute overspill. This has been partially offset by lock ins of £0.7m.

The full year forecast is £21.7m which is £5.3m below the target of £27m. This represents an achievement of 82%. There has been a favourable shift in the forecast of £1.6m which is mainly due to the inclusion of non recurrent gains on disposal of two properties.

The key movements contributing to the forecast variance are:

- **Slippage on beds**
  - **ACP - triage shortfall** which is partially offset by delayed opening of Fitzmary ward (£0.35m). At M7 the forecast has worsened as a result of risk associated with the delayed roll out of the PICU observation units (£0.25m).
  - **NHSI Plan Vs Actual M7**
    - **Total CIPs** 184
    - **No of Schemes**
      - Low: 0 100%
      - Medium: 36 12,182 8,377 45%
      - High: 40 1,358 391 5%
    - **Forecast**
      - Unidentified 0 3,895 14%

- **Corporate Services**
  - **Estate main contributors to the slippage include: **write down of accommodation (£0.2m), restructuring of the team (£0.3m) and property disposals (£0.3m) plus unidentified additional target of £0.61m. The forecast on consultancy cost reductions has been written down to nil: due to the cost pressure associated with the Essentia costs (£0.25m).

<table>
<thead>
<tr>
<th>RAG Ratings &amp; Risks</th>
<th>Income/Cost Type</th>
<th>Total CIPs</th>
<th>No of Schemes</th>
<th>CYP</th>
<th>Forecast</th>
<th>% Plan</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Pay</td>
<td>12,276</td>
<td>11,638</td>
<td>638</td>
<td>27,022</td>
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</tr>
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<td>9,581</td>
<td>8,156</td>
<td>1,425</td>
<td>21,758</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Income</td>
<td>3,106</td>
<td>4,021</td>
<td>915</td>
<td>27,022</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Total</td>
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<td>5,264</td>
<td>5,264</td>
<td></td>
</tr>
</tbody>
</table>

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<table>
<thead>
<tr>
<th>Summary of Progress</th>
<th>Financial Position M7</th>
<th>NHSI Plan Vs Actual M7</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Apr-17</td>
<td>Apr-17</td>
</tr>
<tr>
<td></td>
<td>May-17</td>
<td>Jun-17</td>
</tr>
<tr>
<td></td>
<td>Jul-17</td>
<td>Aug-17</td>
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<tr>
<td></td>
<td>Sep-17</td>
<td>Oct-17</td>
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<td></td>
<td>Nov-17</td>
<td>Dec-17</td>
</tr>
<tr>
<td></td>
<td>Jan-18</td>
<td>Feb-18</td>
</tr>
<tr>
<td></td>
<td>Mar-18</td>
<td>Apr-17</td>
</tr>
</tbody>
</table>

- **Secure**
  - **ACP**
    - **Overview on beds**
      - **ACP - triage shortfall** which is partially offset by delayed opening of Fitzmary ward (£0.35m). At M7 the forecast has worsened as a result of risk associated with the delayed roll out of the PICU observation units (£0.25m).
      - **ACP YTD underachievement** is £1.2m YTD as a result of the impact of acute overspill. This has been partially offset by lock ins of £0.7m.

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REPORT TO THE TRUST BOARD: PUBLIC
28 November 2017

Title | FREEDOM TO Speak Up Guardian Report no.2 2017/18
---|---
Author | Zoë Reed Freedom to Speak Up Guardian and Director of Organisation and Community
Accountable Director | Matthew Patrick Chief Executive

Purpose of the paper

The Freedom to Speak Up Guardian [FTSUG] has been a contractual requirement, and part of the CQC Well Led inspection component, since October 2016. Zoë Reed took up the duties in April 2016 which was prior to the appointment of the National Guardian and establishment of the National Guardian’s Office [NGO] in October 2016. A number of guidance documents have been generated since that time including the job role which states that

*The Freedom to Speak Up Guardian will work alongside Trust leadership teams to support the organisation in becoming a more open and transparent place to work, where all are actively encouraged and enabled to speak up safely.*

The FTSUG reports directly to the Chief Executive and made regular reports to the Board during the set up phase in 2016/2017. It is planned that this financial year there will be 3 Reports to the Board – July 2017, November 2017 and March 2018.

Freedom to Speak Up has been included in the Terms of Reference of the newly formed Equalities and Workforce Board Committee. This will allow for more detailed discussion of the FTSU function and its contribution to the broader Equalities and Workforce agenda.

The Board is asked to note this second report in this financial year. A more detailed report, including plans to more systematically contribute to the development of the culture across the Trust whereby Speaking Up and Being Heard is the norm, will be presented in the third report this year at the March 2018 Board. It will be the FTSUG Annual Report.

Executive summary

The first report from the FTSUG to the Board this financial year was in July 2017. It covered

- News from the National Guardian’s Office [NGO] including the work with the CQC and establishment of Case Review process
- An update on the Promotional Campaign to spread the *Speak Up – Be Heard* message widely amongst staff
- Process underway to gather themes and issues raised as concerns with several services across the Trust
- Developing and maintaining the FTSU system in the Trust
- Learning from cases raised through the FTSU system.

This second Report will cover

- Report from the second FTSUG Conference held on 19th October 2017
- Quarter 2 return to NGO
- Latest briefing from the National Guardian – recommendations from first case review and first Annual Report
- Gathering Themes
- Promotions campaign
1. Report of the Conference

The FTSUG’s Bulletin described the Conference as follows:

“The second Freedom to Speak Up Guardians’ Day was an excellent opportunity for guardians to network, share best practice, attend training workshops and hear from selected speakers and the National Guardian, Dr Henriett Hughes.

With nearly 250 guardians and speaking up representatives from NHS trusts in attendance, the event showcased the achievements from the regional guardian network, updates from the National Guardian and the Minister of State for Health, Philip Dunne MP.

The guest speakers included Freedom to Speak Up Guardians Jo Dawson (University Hospitals of Leicester NHS Trust) and Matt Asbrey (Northamptonshire Healthcare NHS Foundation Trust). Dr Tim Ojo (Consultant General Adult Psychiatrist) talked about conflict management, the importance of shadowing shifts with front-line staff, buddyng up with other guardians, time management and working in partnership.

The first ever Freedom to Speak Up Awards were hosted by BBC Crimewatch presenter Nick Ross, and recognised the innovative work being done nationally by guardians.

The awards featured winners from Blackpool Teaching Hospitals NHS Foundation Trust, Surrey and Borders Partnership NHS Foundation Trust, Mid Yorkshire NHS Trust, University Hospitals of Morecombe Bay NHS Foundation Trust and Royal National Orthopaedic Hospital NHS Trust.”

I attended the Conference, as the Trust’s FTSU Guardian, together with Sam Holmes who is one of the Trust’s FTSU Advocates and the Business Manager Lambeth Psychological Medicine and Integrated Care CAG. Her thoughts on the Conference are set out below:

“I was lucky enough to attend the second Freedom to Speak Up National Guardian day on 19 October at Westminster County Hall.

It was an honour to hear from Dr Henrietta Hughes the National Guardian herself and gain an understanding of what the vision is for the Freedom to Speak Up campaign. Philip Dunne MP for State of Health was also present and shared his views on what a great initiative this is. He informed us that he wore his Freedom to Speak Up lanyard in Parliament and when asked he was “proud to tell them all about Freedom to Speak Up”.

It was a great opportunity to see how other Trusts throughout England are campaigning and to hear of their challenges and how they are getting through these was encouraging.

Having experienced the need for something like this first hand, I feel that once SLaM has adopted this into everyday practice it will make things easier for staff to speak up and be heard.”

2. National Guardian’s Office submission

All Trusts are required to submit a quarterly return to the National Guardians Office on the cases presented to Freedom to Speak up Guardians, and this is then published on their web pages.

The Trust has recently submitted quarter 2 data on cases that were presented between 1 July and 30 September 2017. This is summarised as follows:

<table>
<thead>
<tr>
<th>Cases presented 1 July – 30 Sept 2017</th>
<th>Classification of cases raised – by Professional Group</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Nurses</td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Page 120 of 130
a. Number of issues raised, and whether the case was raised anonymously

<table>
<thead>
<tr>
<th>Cases presented 1 July – 30 Sept 2017</th>
<th>Issues being raised:</th>
<th>Number of cases</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Cases with an element of Patient safety/quality</td>
<td>1</td>
</tr>
<tr>
<td></td>
<td>Cases related to behaviours incl. bullying and harassment</td>
<td>2</td>
</tr>
<tr>
<td></td>
<td>Cases where detriment suffered as a result of speaking up</td>
<td>1</td>
</tr>
<tr>
<td></td>
<td>Total</td>
<td>4</td>
</tr>
<tr>
<td></td>
<td>Cases raised anonymously</td>
<td>0</td>
</tr>
</tbody>
</table>

b. The Trust was asked about themes from respondents and about whether they would use the Freedom to Speak up system again:
- The 4 respondents said yes they would the system again
- The three most common themes from the responses were:
  - I felt listened to
  - Can see the benefit of the Freedom to Speak up system
  - Would use Freedom to speak up system again

c. The Trust was also asked for a brief summary on the Trust’s learning points identified over the quarter:
- A need for better communication and staff involvement during re-structuring
- Need to promote network of Ambassadors and Advocates more widely

d. At the National Conference Dr Henrietta Hughes reported that during its first full year of operation, October 2016 – October 2017, nearly 4,000 cases had been raised with FTSUG across the Country. Of those about a 1,000 involved patient safety. Our Q2 return is the same ratio with 1 out of the 4 cases having a patient safety element. It is now clear that encouraging speaking up by staff about staff experience as well as patient safety is within the FTSUG’s brief.

e. The National Guardian’s Office has just published the Q2 individual Trust returns. The headlines are
- 1,528 cases were raised to Freedom to Speak Up Guardians / ambassadors / champions.
- 491 of these cases included an element of patient safety / quality of care.
- 718 included elements of bullying and harassment.
- 83 related to incidents where the person speaking up may have suffered some form of detriment.
- 339 anonymous cases were received.
- 19 trusts did not receive any cases through their Freedom to Speak Up Guardian.
- 196 of the 233 trusts listed in the NGO directory sent returns

f. The FTSUG attends network meetings of fellow Guardians of both London Region and Mental Health and Community Trusts. These are useful places to exchange ideas as well as discuss issues with the NGO. Colleagues in other Trusts have pointed out that the categories by which the issues are analysed by the NGO, as above, have not been defined and therefore are of limited comparative value at this stage. Further, the categorization is based on an assessment by the FTSUG gleaned from discussions with the person raising the concern rather than any more detailed investigation.

3. Latest Briefing from the National Guardian

The National Guardian’s Office has circulated the letter from the National Guardian which is reproduced in full below

“I am pleased to share with you my first published case review about the speaking up culture, processes and policies at Southport and Ormskirk Hospital NHS Trust.”
I have also marked my first year as National Guardian for the NHS with the publication of the National Guardian’s Office Annual Report 2017, highlighting the work of Freedom to Speak Up Guardians.

**Southport and Ormskirk Hospital NHS Trust case review**
The report includes 22 recommendations for the trust and one for the Care Quality Commission. The review identified failures of the trust to act appropriately on multiple and serious allegations and a number of wide ranging issues that represented significant barriers to speaking up. These included a culture of bullying and alleged discriminatory behaviour.

The recommendations for Southport and Ormskirk Hospital NHS Trust and the Care Quality Commission are not intended to criticise, but instead to support improvement.

Our key findings included
- Evidence of a longstanding culture where the trust did not respond appropriately to specific and serious concerns raised by its workers
- Significant evidence of a bullying culture within the trust where staff were too afraid to speak up, or they alleged detriment at the hands of their colleagues for having done so
- Failure of the trust to meet its responsibilities regarding equality and diversity resulting in black and ethnic minority staff not feeling free to speak up
- However, there was also evidence at the time of our review that a new trust leadership team was taking steps to improve the trust’s speaking up processes, policies and culture, including a revision of the existing speaking up policy to bring it in line with national minimum standards set by NHS Improvement

**National Guardian annual report**
Having been in post for just over a year my annual report provides an overview of the activity and achievements of Freedom to Speak Up Guardians in NHS trusts across England.

Amongst our most notable successes during the year are:
- The appointment of over 500 individuals across all trusts in a Freedom to Speak Up Guardian, Champion or Ambassador role representing a powerful social movement
- The creation of regional networks to support guardians and delivery of two national training and development events
- Development and delivery of highly-rated foundation training for guardians
- Incorporation of Freedom to Speak Up into the Care Quality Commission well-led inspection framework
- The first survey of Freedom to Speak Up Guardians and the development of principles for the role based on the results
- The start of regular publication of speaking up data
- Co-production and roll-out of a pilot case review process based on the principles set out in the Freedom to Speak Up report by Sir Robert Francis QC

Here are some comments from the chief executives of our sponsoring bodies:

“It’s great to see that the National Guardian’s Office has accomplished so much in its first year, making real progress in supporting staff in hospital trusts to raise concerns at work – to improve the service for patients. There is clearly more to do and we will continue to work closely with the National Guardian to ensure we support Freedom to Speak Up across the NHS.”

**Jim Mackey, NHS Improvement**

“Sir Robert Francis’ seminal Inquiry Report into Mid Staffordshire NHS Foundation Trust exposed unacceptable patient care and a culture which meant staff did not raise concerns. His report Freedom to Speak Up focused on creating a more open and honest culture in the NHS where staff could raise concerns. The creation of Freedom to Speak Up Guardians supported by the National Guardian for the NHS was a fundamental contribution to supporting a more open culture within the NHS. I am delighted to see in the first Annual Report from Dr Henrietta Hughes, the National Guardian and her team, the progress that has been made at a national and local level to establish the roles of the guardians.”
“I know they are now supporting staff to raise concerns. In many cases there is evidence that change happens following these conversations. In others, concerns are not always heard and change is harder to achieve so guardians are supporting staff. Nationally, Henrietta and her team are conducting reviews into some NHS organisations with the view that organisational learning is possible at a national and local level. Changing the culture of a system is not easy. This report shows that the Freedom to Speak Up Guardian involvement has begun the work.”

Sir David Behan, Care Quality Commission

“Recognising the importance of Freedom to Speak up Guardians, NHS England is now increasing from one to 15 the number of guardians within our own organisation, and we want at least a third of them to be from black and minority ethnic backgrounds. We are also funding and supporting broader action across the NHS on safe spaces for staff to raise concerns and on better support for staff health and wellbeing.”

Simon Stevens, NHS England

We know that we are on a journey and that our work to date represents just the first steps on the path towards speaking up becoming ‘business as usual’ across all NHS organisations.

Thank you for your ongoing support helping to improve staff experience and patient care.”

4. Identifying Themes
In the July Report it was explained that a number of services have indicated that staff also raise issues of concern with them. In addition, some other functions, incidents and complaints for example, might well have learning about how earlier Speaking Up and Being Heard might have prevented serious issues occurring. In practice it has proved more difficult for individual services to identify themes than originally envisaged. The original purpose of this exercise was to provide data to help shape action aimed at moving the Trust closer to the organisation becoming a more open and transparent place to work, where all are actively encouraged and enabled to speak up safely. It is suggested that this could be something the Equalities and Workforce Committee might want to discuss so that if it is a route to be explored then the requirements are more tightly drawn.

5. Promotion Campaign
One of the learning points in the National Guardian’s first Case Review, reported above, is that the FTSUG function needed to be well known across the Trust. This remains an area where there is a requirement for continuous attention to seize opportunities to promote the FTSUG function. It is not yet well known across the Trust and crucial to this is the need to recruit more Advocates and for them to take the time to make themselves known across their allocated area. Evidence is that it is only when Advocates “walk the floor” and become well known that issues will be raised in a timely way, so that they can be dealt with informally and more serious issues avoided. It is proposed that the new Internal Communications Manager be asked to help develop a more on-going promotions campaign together with colleagues from the Ambassadors and Advocates Network.

6. Action
The Board is asked to note this second report in 2017/18 of the Freedom to Speak Up Guardian and refer any issues for detailed discussion to the Equalities and Workforce Committee.

The Board is asked to note that the final report this year will be made to the Board in March 2018 and will be the FTSUG Annual Report.

Zoe Reed
Freedom to Speak Up Guardian
21st November 2017
REPORT TO THE TRUST BOARD:  PUBLIC

28th November 2017

<table>
<thead>
<tr>
<th>Title</th>
<th>WRES IMPLEMENTATION PLAN Year One – baseline metrics</th>
</tr>
</thead>
<tbody>
<tr>
<td>Author</td>
<td>Michael Kelly and Zoë Reed with Tackling Snowy White Peaks Working Party – Mike Franklin NED; Arleen Elson Chair BME Staff Network; Michael Kelly and Patience McLean Human Resources Directorate and Zoë Reed.</td>
</tr>
<tr>
<td>Accountable Director</td>
<td>Matthew Patrick, Chief Executive</td>
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</table>

**Purpose of the paper**

The Board approved a report at its September 2017 meeting which outlined Year One of an Implementation Plan to deliver the Board’s Workforce Race Equality Standard [WRES] Aspirations. These Aspirations were approved by the Board at its May 2017 meeting and are to ensure that by 2021:

- Band 8c and above – has proportionate representation
- Disciplinary Proceedings – has proportionate referral
- Career Opportunities – there is staff survey reported proportionate access

The Implementation Plan outlined that a number of key metrics would be reported back to the Board which would then provide a baseline for which monitoring of progress could be made, these included:

- Proportion of BME and White staff in Bands 8c+.
- Proportion of BME and White staff entering formal disciplinary processes.
- The relative success from application to shortlisting to appointment for White and BME applicants for Band 7+.

The Board is asked to note the baseline metrics. It is also asked to note that the Equalities and Workforce Committee of the Board has now been established. This will retain strategic oversight of the
delivery of the WRES Implementation Plan. A substantial amount of time has been earmarked to discuss this and other equality items at its January 2018 meeting. Progress against the Implementation Plan will also be monitored by the Trust’s Equality, Diversity and Inclusion Group which will escalate any areas of concern to the Senior Management Team.

Executive summary

Within the report are baseline metrics that will be used to monitor progress against the plan. The metrics cover the proportion of staff from a BME and White ethnic origin at Band 8C+, the proportion of BME staff entering formal disciplinary processes which has been significantly higher than White staff and the likely success of appointment from recruitment for BME and White staff at Band 7 and above. These metrics will be built in to the overall dashboard that is being developed to provide assurance to the new Board Equalities and Workforce Committee. This dashboard will use the rigour of QI methodology to track progress and identify areas for remedial action.

The overall Implementation Plan was described in detail in the September Report. It comprises 15 components under the 4 headings of

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

Each component is a linked part of the whole and the Implementation Plan requires progress on each component to be successful. This is only Year One of the 4-Year Plan and careful track needs to be kept on the implementation of each component so that progress can be assessed and the Plan revised and improved as necessary for Year 2. The main resource requirements were also detailed in the report.

Central to the delivery is the creation of a dedicated resource to focus on implementation. A job description for this post has been developed and is being prepared for recruitment.

Committees where this item has been considered

<table>
<thead>
<tr>
<th>Date</th>
<th>Committee / Meeting</th>
</tr>
</thead>
<tbody>
<tr>
<td>23.05.2017</td>
<td>Trust Board</td>
</tr>
<tr>
<td>19.09.2017</td>
<td>Trust Board</td>
</tr>
</tbody>
</table>
Workforce Baseline Data

Aspiration 1: Banda 8c and above posts – proportionate representation

BME Staff Representation in Bands 8C+.

The following table outlines the number of staff in bands 8c and above as at 31st October 2017 from either a White or BME ethnic origin.

<table>
<thead>
<tr>
<th>Band/Grade</th>
<th>White</th>
<th>BME</th>
</tr>
</thead>
<tbody>
<tr>
<td>Band 8 C</td>
<td>70</td>
<td>15</td>
</tr>
<tr>
<td>Band 8 D</td>
<td>19</td>
<td>0</td>
</tr>
<tr>
<td>Band 9</td>
<td>9</td>
<td>1</td>
</tr>
<tr>
<td>Above Band 9</td>
<td>7</td>
<td>2</td>
</tr>
<tr>
<td>VSMs</td>
<td>6</td>
<td>1</td>
</tr>
<tr>
<td>Medical Managers</td>
<td>6</td>
<td>1</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td>117 (85%)</td>
<td>20 (15%)</td>
</tr>
</tbody>
</table>

The Board’s Aspiration, agreed in May 2017, is to increase the number of BME staff to a representative proportion of the workforce by 2021. The proportion of BME staff in our total workforce is 41%. 41% of 137 is 56 posts which means that we need to increase the number of post holders from BME backgrounds by an additional 36 posts. The Board Aspiration is that we make linear progress until full proportionate numbers in 2021. The target for Year One is thus 9 more BME staff in Band 8c and above posts.

There will be twice-yearly tracking of these numbers with a full report at the end of year one [October 2018].

Recruitment Success Band 7+

The following is the baseline data for all recruitment for Bands 7 and above and the relative success of being shortlisted from application and the success of being appointed from shortlisting for White and BME applicants. The data covers the period from 1st November 2016 to 31st October 2017.

<table>
<thead>
<tr>
<th>Ethnic Category</th>
<th>No. Applied</th>
<th>% Applied</th>
<th>No. Shortlisted</th>
<th>% Shortlisted</th>
<th>No. Appointed</th>
<th>% Appointed</th>
</tr>
</thead>
<tbody>
<tr>
<td>White</td>
<td>1358</td>
<td>50.3</td>
<td>484</td>
<td>60.3</td>
<td>100</td>
<td>71.9</td>
</tr>
<tr>
<td>BME</td>
<td>1339</td>
<td>49.7</td>
<td>318</td>
<td>39.7</td>
<td>39</td>
<td>29.1</td>
</tr>
</tbody>
</table>

Within the Board Aspirations in this area no targets were set. It might be something the Equalities and Workforce Committee could consider in January 2018.
Aspiration 2: Disciplinary Proceedings – proportionate referral

Proportion of BME and White Staff entering Formal Disciplinary Processes.

The data below covers a year from 1st November 2016 to 31st October 2017 for all Trust staff who have entered a formal disciplinary process.

<table>
<thead>
<tr>
<th>Ethnicity</th>
<th>Number</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>BME</td>
<td>24</td>
<td>69%</td>
</tr>
<tr>
<td>White</td>
<td>9</td>
<td>26%</td>
</tr>
<tr>
<td>Not stated</td>
<td>2</td>
<td>5%</td>
</tr>
</tbody>
</table>

Over the 12 month period there has been a significantly higher proportion of BME staff entering formal disciplinary processes compared to White counterparts. BME staff make up 41% of our total staff.

There will be twice-yearly tracking on the proportion of BME staff involved in disciplinary proceedings. The aim is to make significant progress in reducing the over-representation within the first year. BME staff are currently c.3.5 times more likely to be the subject of disciplinary action than white staff. A target reduction to 2.0 times is proposed. 6 monthly reports will be made on progress towards achievement of this target in line with WRES national reporting.

Reflect and Review Checklist.

Review and Reflect checklists were introduced to force a pause before the instigation of a formal disciplinary process, with executive level scrutiny. Since implementation on 24th July 2017 there have been 5 Reflect and Review Checklists completed, although one has been subsequently withdrawn. The remaining four have been approved to proceed to disciplinary investigation. Feedback from HR Business Partners indicates that a further 5 potential cases which were being considered for disciplinary investigation have since followed an alternative approach.

Aspiration 3: Career Opportunities – perceived proportionate access

- There will be yearly reporting of the annual staff survey results on access to career opportunities. BME staff currently score this at 66% as compared with 85% for White staff. The aim is for linear closure of the gap. A target of 5% improvement is set for Year 1.
- There will be twice-yearly tracking of numbers of BME staff participating as a result of this Implementation Plan in (a) Band 7 and upwards recruitment panels [as part of this Plan] (b) mentoring and coaching (c) Leadership Academy and other BME specific development programmes

The report on the Staff Survey Results will be made to the January Board meeting as part of the regular workforce report.

We will need to develop a mechanism for recording and reporting the number of staff undertaking any Leadership Academy and other specific BME development programmes. It is the intention that this should
be identified and included and part of an individual’s Personal Development Plan (PDP) as part of their annual appraisal and then recorded on the LEAP Education and Training system. We are in discussion with the Leadership Academy about information they may have for Trust staff who have completed courses with them. Once the Band 7 and upwards BME band 4-7 sitting on recruitment panels process is underway and the Mentoring and Coaching programme started, tracking will commence on these areas too. This is likely to be in the first quarter of 2018.

Michael Kelly
Zoë Reed
23rd November 2017
REPORT TO THE TRUST BOARD: PUBLIC
28 November 2017

<table>
<thead>
<tr>
<th>Title</th>
<th>Report from previous month’s Part 2 meeting</th>
</tr>
</thead>
<tbody>
<tr>
<td>Author</td>
<td>Charlotte Hudson, Deputy Director of Corporate Governance</td>
</tr>
<tr>
<td>Accountable Director</td>
<td>Rachel Evans, Director of Corporate Affairs</td>
</tr>
</tbody>
</table>

**Purpose of the paper**

To produce a summary report for consideration in the part of the Board meeting held in public which lists the items which were discussed in the Part 2 (private) meeting the previous month.

**Executive summary**

The detail below refers to October 2017 when there were four issues for discussion.

<table>
<thead>
<tr>
<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>BOD PTII 38/17</td>
<td>Discussion with Healthcare UK</td>
<td>The Board received a presentation setting out the institutional support available for NHS Trusts undertaking work overseas.</td>
<td>Altaf Kara</td>
<td>Commercial in confidence.</td>
</tr>
<tr>
<td>BOD PTII 39/17</td>
<td>Staff reward</td>
<td>The Board considered recommendations from the Equalities and Workforce Committee</td>
<td>Sally Storey</td>
<td>Prejudice to the free and frank exchange of views</td>
</tr>
<tr>
<td>BOD PTII 40/17</td>
<td>Serious Incident Focus</td>
<td>The Board has a statutory obligation to review serious untoward incidents (SUI), identify root causes and identify lessons learned to prevent further occurrence.</td>
<td>Beverley Murphy</td>
<td>Investigations &amp; proceedings conducted by public authorities</td>
</tr>
<tr>
<td>BOD PTII 41/17</td>
<td>Digital Services Strategy</td>
<td>The Board considered commercial elements of the strategy.</td>
<td>Gus Heafield</td>
<td>Commercial in confidence</td>
</tr>
</tbody>
</table>
Board of Directors Meeting
To be held 19th December 2017
3:00pm Learning Centre, Maudsley Hospital

AGENDA: Part 1

Opening Matters
1. Welcome, apologies for absence, declarations of interest
2. Minutes, Action log review
3. Patient Story - Kathryn
4. Chief Executive’s Report Rachel

Quality & Safety
5. Quality Improvement Update Michael
6. Physical Health Care Beverley
7. Q2 Incidents & Complaints Report Beverley

Governance
8. Business Development & Investment Committee Update Altaf
9. Finance & Performance Committee Update Steven
10. Quality Committee Update Beverley
11. Council of Governors Update Rachel

Performance
12. Workforce Update Sally

For Noting
15. Report from previous Month’s Part II
16. Wrap-up and Next Meeting

The next Board of Directors Meeting will be held on 23rd January 2018 at 2:30pm, in the Learning Centre, Maudsley Hospital

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