AGENDA: Part 1

Opening Matters
1. Welcome, apologies for absence, declarations of interest
2. Minutes, Action log review
3. Patient Story - Corporate OT/Nursing Directorate
4. Chief Executive’s Report

Quality & Safety
5. Quality Improvement Update
6. Inpatient Safe Staffing Annual Report
7. Q2 Incidents & Complaints Report

Governance
8. Business Development & Investment Committee Update
9. Finance & Performance Committee Update
10. Quality Committee Update
11. New Associate Hospital Managers for Board of Directors Approval
12. Council of Governors Update

Performance
13. Equalities and Workforce Committee Terms of Reference
15. Finance Report

For Noting
16. NExT Director Scheme
17. Report from previous Month’s Part II
18. 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.

web site: www.slam.nhs.uk
MINUTES OF THE HUNDRED AND TWELFTH MEETING OF THE BOARD OF DIRECTORS OF
THE SOUTH LONDON AND MAUDSLEY NHS FOUNDATION TRUST
HELD ON 28 NOVEMBER 2017

PRESENT

Roger Paffard  Chair
Kristin Dominy  Chief Operating Officer
Rachel Evans  Director of Corporate Affairs
Professor Ian Everall  Non-Executive Director
Mike Franklin  Non-Executive Director
Duncan Hames  Non-Executive Director
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
Anna Walker  Non-Executive Director

IN ATTENDANCE

Andy Bell  Finance Director
Jenny Cobrely  Lead Governor
Dr Gill Dale  Director of Research Quality
Dr Fiona Gaughran  Director of Research and Development
Kathryn Hill  Head of Experience, Participation and Involvement
Sam Holmes  Business Manager
Charlotte Hudson  Deputy Director of Corporate Governance
Michael Kelly  Deputy Human Resources Director
Roger Oliver  Co-Chair of the Family and Carers’ Committee
Zoë Reed  Director of Organisation and Community & Freedom to Speak Up Guardian
Gabrielle Richards  Head of Inclusion, Recovery; Professional Head of Occupational Therapy and AHPs / Co-Chair of the Family and Carers’ Committee
Sarah Thomas  Head of Communications
Nick Walker  Liaison Financial Services

APOLOGIES

Alan Downey  Non-Executive Director
Gus Heafield  Chief Financial Officer
Sally Storey  Interim Director of Human Resources

DECLARATIONS OF INTEREST

None

MINUTES

The minutes of the Board held on 31 October 2017 were 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.
BOD 155/17 MATTERS ARISING / ACTION POINTS REVIEW

Beverley Murphy requested the Board’s agreement to delay the Physical Healthcare report due for consideration at the December Board meeting to January’s Board meeting, in order to ensure that the strategy adequately addresses concerns.

The Board

Agreed to the postponement of the Physical Healthcare report from December 2017 to January 2018.

BOD 156/17 CHIEF EXECUTIVE’S REPORT

Matthew Patrick recognised the challenges associated with Q3, including delivery of the year-end financial position and the pressure brought by the onset of winter. Forecasts had suggested that this winter would be difficult, and it has proved to be so already. Teams have had to absorb wild fluctuations in admissions. He acknowledged that every day, people across the Trust are doing an incredible job in managing to deliver what they do.

Matthew Patrick congratulated Dr Sridevi Kalidindi for winning the Psychiatrist of the Year 2017 prize from the Royal College of Psychiatrists, a tremendous achievement.

The Cavendish Square Group - a collaboration of the ten London NHS Mental Health Trusts – met in early November. The new Mental Health Lead for the Metropolitan Police Service (MPS), Commander Richard Smith, was also in attendance, and they had a very positive meeting. There is currently some anxiety owing to the restructure of MPS boroughs, so it is important to have strength of leadership.

The South London Mental Health Community Partnership has made its first shared appointment in the New Models of Care Director, Jeremy Walsh from South West London and St George’s. Both New Models of Care services are going well; the forensics work is showing considerable results and CAMHS pathways are being redesigned with a new 8-bed unit at the Bethlem Royal Hospital.

The Board

Noted the Report.

BOD 157/17 RESEARCH AND DEVELOPMENT STRATEGY

Dr Fiona Gaughran, Director of Research and Development, and Dr Gill Dale, Director of Research Quality, attended to present this report.

The aim of the strategy is to embed research and development in core business, developing care based on research evidence, as it is integral to everything the Trust does as part of the QI agenda.

The defined aims are 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, and to enhance communication pathways for R&D.

R&D activity needs to be effectively measured and meet performance indicators from the National Institute for Health Research (NIHR). A priority is to enhance communication pathways within the Trust so that service users, carers and staff understand how they can participate and know what the research is showing.

Mike Franklin asked whether the strategy clearly shows how the value of the research will be communicated, particularly to groups who may be sceptical or reluctant; it was confirmed that a clear measurement of research activity is proposed, with PPI involvement and a communications / media strategy. Input for NEDs in this was welcomed. The strategy would benefit from clarifying the link with QI.

Anna Walker was interested in the provenance of the research budget, and Fiona Gaughran highlighted the different sources of funding, including NIHR, through the Biomedical Research Centre (BRC) and grants from principle investors.

Anna Walker asked how the process outlined in the strategy is linked to outcome priorities; it was agreed that a focus on outcomes would be considered in more depth alongside IoPPN with a view to communicating them. Roger Paffard felt that the metrics as outlined were good, but that the next iteration of the strategy could include a smaller number of key metrics with numbers to support the aims.

**Action:** R&D team to return to the Board with an update report in a year’s time, reflecting request for (a) a stronger link to outcomes and (b) fewer metrics but with supporting data.

Matthew Patrick felt that it could be easy to lose sight of the impact of research and how the Trust does delivers evidence-based care. It was agreed that it would be useful to create a list to demonstrate this. For example, IAPT services arose out of research in CBT.

The Board discussed academic fellowship positions and developing the next generation of a research-active workforce, noting that part of the strategy was to develop a career structure for those people in clinical posts who would like to do research. Work to communicate with staff has started but there is room for more initiatives, such as Research Champions. Altaf Kara could see how this strategy could be included in the pillars of the overarching communications strategy.

**Action:** R&D team to work with Trust Communications team to ensure that the R&D strategy is included in the Trust-wide communications strategy.

June Mulroy connected staff disaffection around lack of training to potential opportunities arising from research in clinical practice, and felt that it should be promoted more. She also highlighted potential commercial opportunities arising from R&D and offered assistance in preparing business cases for any arising prospects.

Roger Paffard thanked the presenters for an excellent report in a key priority area.

**The Board**

**Approved** the Strategy.
Gabrielle Richards, Head of Inclusion, Recovery, Professional Head of Occupational Therapy and AHPs / Co-Chair of the Family and Carers’ Committee, and Roger Oliver, Co-Chair of the Family and Carers’ Committee, attended to present this report. The updated strategy was taken as read. All presentations on the strategy will be co-produced going forward.

The strategy is underpinned by the overarching vision, namely that families and carers will be valued and supported throughout their contact with SLaM’s services, recognising them as expert partners in care. The aim is to improve the experience of all who encounter SLaM’s services and improve health outcomes of the local population.

The strategy has five implementation priorities: Friends, Family and Carer Involvement; Informing Friends, Families and Carers; Supporting Friends, Families and Carers; Developing staff to work with Friends, Families and Carers; and Working in Partnership.

The Family and Carers’ Committee met in the last week to agree future activity for the next twelve months. The Committee will work with Cath Gormally, Director of Community Care, to embed the Carers’ Engagement and Support Plan (CESP) to ensure that the target of 70% of identified carers is achieved. The CESP does not replace the carers’ assessment, which is the responsibility of the local authorities’ appointed agents to complete. Some of the completion rates are worryingly low (in Croydon, only 19 are recorded for Q3 2017). The CESP 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 and whether information has been given about the type of support available, as well as recording whether information about the role of the key health professional has been given.

**Action:** Board to be provided with up-to-date information on how many carers’ assessments are being conducted across the boroughs.

The Trust is working towards becoming part of the Triangle of Care, and to support this membership by undertaking a self-assessment benchmarking exercise in all inpatient settings. Support from a Non-Executive Director is required to help lead and develop a plan, and resources are required to undertake and collate the data. Regardless of whether the Trust formally joins the membership, the principles and associated framework are worth committing to as best practice. Beverley Murphy offered to provide the necessary resources to support the programme.

The Committee is also providing support to QI projects which aim to improve work with carers.

Julie Hollyman congratulated the committee for the progress made. She considered its work in light of the current financial climate and the resultant expectations / burdens on carers. Gabrielle Richards confirmed that the committee has discussed the pressures on carers at length, including the need for clinical teams to check their assumptions on what carers do. BME carers are under-represented and this is a matter of some focus.

Beverley Murphy reported that while 1,500 carers’ support plans have been completed, this is a low figure. Discussions are held at Quality Governance meetings, looking at the different challenges on each CAG. There is recognition that not all
carers are happy to identify as such, so thought must be given to how carer information can be captured in a way that is not bound to the form.

The Board

Noted the Report.

BOD 159/17 LEARNING FROM DEATHS

Michael Holland presented the Q2 update for discussion, as well as proposals for the process of Board oversight and involvement in the Mortality Review Group.

Of 100 deaths reported on Datix in Q2, 79 were from natural causes. Seven cases require a full Serious Incident Investigation.

The Mortality Review Policy was ratified by the Clinical Policy Working Group in September 2017, and the Board was asked to formally approve it. The Board’s views were sought on whether the Mortality Review Group should feed in to the Quality Committee, and whether a Non-Executive Director should sit on the group. Anna Walker asked for time to consider this in conjunction with Julie Hollyman and Beverley Murphy, but noted that the policy already refers to Quality Committee overseeing the Mortality Review Group, so there needs to be clarity between the relationships so that the process is coherent and without duplication.

Action: Anna Walker, in discussion with others, to consider governance of Mortality Review Group in relation to Quality Committee; Michael Holland to update terms of reference with outcome.

Michael Holland reported that the QI process is also under review to identify and action learning within the Mortality Review Group, to monitor and maintain workstreams and to embed its work with the physical healthcare strategy.

Duncan Hames queried whether it would be instructive for the Board to receive more information by way of learning from the data within each quarterly report, and whether comparisons in data (either with other Trusts or with previous quarters) would be helpful. Michael Holland explained that thematic reviews, as per guidelines on mortality review, come to the Board on an annual basis as it is only after a year that there is enough data to pull out themes, whether in relation to SIs or less serious incidents. There is no specific reporting guidance for mental health trusts and so there are different processes across London, and therefore comparison is not meaningful. However, examples of learning would be brought to future updates.

Mike Franklin queried whether the timescales to complete the Mortality Report Form are realistic given potential delays in receiving information (e.g. death certificate) or where circumstances of the death are disputed. Michael Holland explained that the Trust is held to a standard of completing the form in a 72-hour period, but if there is a change in the understanding of the circumstances surrounding the death, the case can be re-opened.

Beverley Murphy reported that the Quality Committee considered the Duty of Candour annual assessment at its last meeting, which showed that the Trust did not perform as well against its responsibilities in 2016 as it did in 2014. Another assessment will be undertaken when 2017’s data is available.
In October, Anna Walker attended an NHSI event on Learning from Deaths and Non-Executive Directors’ related responsibilities. NHSI emphasised that Trusts must ensure that the learning is well understood, and that there is a clear process for embedding what has been learned. Anna Walker highlighted that the process must be reviewed before any statement is made in the annual report.

The Board

Approved the policy, subject to a decision regarding the Mortality Review Group’s relationship with the Quality Committee.

BOD 160/17 COUNCIL OF GOVERNORS UPDATE

Jenny Cobley, Lead Governor, attended to present the report and expressed gratitude on behalf of the Council of Governors to staff and NEDs who have attended Governor working groups; to the Corporate Affairs team for their support; and to the NEDs with whom the Governors had a very useful meeting in October.

Congratulations were offered to those involved in reducing the Out of Area beds performance.

Governors are pleased to see the establishment of an Equalities and Workforce Committee to give more emphasis to recruitment and retention and the welfare of staff in challenging times.

On behalf of the Governors, Jenny Cobley expressed concern to see the increasing pressure on many services, including in A&E and in the Community Teams. The Governors remain concerned about the substantial pressures on community staff and would like to know more about plans to reassess the workload of community teams.

The Governors plan to lobby local MPs regarding mental health funding. In their view, the Trust “bends over backwards” to provide safe services, but this may not be possible if further cuts occur. A letter to local MPs is being prepared and the Governors have meetings scheduled with Helen Hayes MP and a 38 Degrees group in Dulwich, which is also campaigning for more mental health funding.

Southwark CCG has responded to the Governors’ letter about benchmarking figures across CCGs. Jenny Cobley and Brian Lumsden have also signed a letter to the Deputy Mayor for Transport from Lead Governors in London, asking if they can do anything to help NHS staff with transport costs.

The Board

Noted the Report.

BOD 161/17 EQUALITIES AND WORKFORCE COMMITTEE UPDATE

Roger Paffard reported that the inaugural meeting of the Committee met on 31 October 2017. The key issues summary provided in the Board paper gave an insight into the future agenda of the Committee. The Terms of Reference are under consideration and will be brought back to the Board. A key risk is that while essential (including mandatory and statutory) training compliance has shown steady improvement, some elements remain below target. Detailed remedial action plans are in progress.
The Board

Noted the Report.

BOD 162/17 PERFORMANCE REPORT

Kris Dominy presented the report, which had been updated in order to provide additional information regarding the run rate on areas of performance and targeted the pressures on which the Board should be sighted.

The contract refresh negotiations are underway and it is proving to be challenging, particularly in relation to QIPP.

Pressures from Emergency Departments continue to have an impact, challenging the bed base. The approach with delayed transfers of care has the engagement of Commissioners. Matthew Patrick requested a borough-by-borough breakdown of OBD performance.

The issue of low compliance with essential training in some areas is reviewed at every PACMAN meeting with clinical services, but improvements are being made.

Julie Hollyman sought assurance that, in relation to placements, particularly in Southwark, quality is the key issue and not just the cost. Kris Dominy confirmed that the Trust is working with Commissioners to review efficiency and to ensure that assessments are against need, leading to the most appropriate placement. There is evidence of good work done in the IPSA (Integrated Personalised Support Alliance) in Lambeth and there are discussions underway about implementing a similar structure in other boroughs. There is also a very specific focus on very long lengths of stay across all adult acute inpatient wards.

The Board

Noted the Report.

BOD 163/17 FINANCE REPORT

Andy Bell presented this report in the absence of Gus Heafield. The report was taken as read.

Overall the Trust’s outturn target of £2.2m surplus is challenging, but achievable. The Month 7 YTD surplus is mainly the result of the disposal of two properties. The overall cash position remains strong owing to known and managed capital underspends. Acute overspill has been held at, or close to, zero for two months although Southwark and Lewisham placements continue to be difficult. Agency spend remains better than the cap set by NHSI. In terms of CIP, the Trust is on track to have a gap of £5.3m in savings by year end, and QIPP recovery remains challenging.

There are concerted efforts being made across the Trust to meet the control total. CEO assurance meetings have taken place to ensure a robust approach to each CAG and Corporate area's financial performance. In terms of 2018/19 planning contractual refreshes with commissioners are in progress.
Duncan Hames queried the options open to the Trust where it looks as though the contractual goalposts are being moved; Matthew Patrick clarified that there haven’t been shifts in the 2-year contractual position as such, it is more that there is push-back on how the system is functioning in preparation for 2018-19.

Alan Downey repeated his previously-made point about pushing back on the control total, and sought an indicative timescale as to when that decision should be made. It was agreed that once data from Q3 is closed, that conversation can be held. June Mulroy intends to bring a paper to the Board from the Finance and Performance Committee with recommendations.

**Action:** June Mulroy to schedule time at a Board meeting in early 2018 to set out FPC’s recommendations on next year’s control total.

The Board

Noted the Report.

**BOD 164/17 PROPOSAL TO APPOINT DIRECTOR OF STRATEGY AND COMMERCIAL AS AN EXECUTIVE DIRECTOR**

The proposal was approved unanimously.

The Board

Appointed Altaf Kara as an Executive Director of the Board.

**BOD 165/17 FREEDOM TO SPEAK UP GUARDIAN BOARD REPORT**

The report was taken as read.

The Board

Noted the Report.

**BOD 166/17 WRES IMPLEMENTATION PLAN YEAR ONE – BASELINE METRICS**

The report was taken as read.

The Board

Noted the Report.

**BOD 167/17 REPORT FROM PREVIOUS MONTH’S PART II**

The report was taken as read.

The Board

Noted the Report.
BOD 168/17 ANY OTHER BUSINESS

The Board discussed the King’s Health Partners’ Cardio-Vascular Institute report, which SLaM has not yet signed off. It was agreed that the Board would delegate responsibility for this to Matthew Patrick and Altaf Kara on the basis that there is no financial commitment from SLaM. Ian Everall emphasised the comorbidity of cardio-vascular issues and mental health, and felt that this could be more strongly represented in future.

The Board

Approved sign-off of the report, on the basis that there is no financial commitment to SLaM.

BOD 169/17 WRAP UP, NEXT MEETING DATE

The date of the next meeting will be:
Tuesday 19 December 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 19 December 2017 – Action points

<table>
<thead>
<tr>
<th>Ref</th>
<th>Issue/Board Paper</th>
<th>Action</th>
<th>By</th>
<th>When</th>
<th>Status</th>
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<tbody>
<tr>
<td><strong>September 2017</strong></td>
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<tr>
<td>2</td>
<td>Mental Health Law Management Annual Report April 2016 - March 2017</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>
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<td>4</td>
<td>Matters Arising</td>
<td>Estates dashboard to be scheduled for December 2017 Board meeting.</td>
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<td>Dec 2017</td>
<td>On agenda for January 2018</td>
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<td>5</td>
<td>Matters Arising</td>
<td>Schedule Community QUESTT dashboard for future meeting.</td>
<td>KD</td>
<td>Jan 2018</td>
<td>In hand</td>
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<td>6</td>
<td>Development of SLaM Digital Strategy</td>
<td>The final draft of the strategy will be brought back at a later date.</td>
<td>RE</td>
<td>Jan 2018</td>
<td>On agenda for January 2018</td>
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<td>7</td>
<td>Development of SLaM Digital Strategy</td>
<td>Michael Holland to make a recommendation on QI / Digital Strategy governance when item returns to the Board.</td>
<td>RE</td>
<td>Jan 2018</td>
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<td><strong>November 2017</strong></td>
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<td>Research and Development Strategy</td>
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<td>Jan 2018</td>
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<td>MH</td>
<td>Jan 2018</td>
<td>In hand</td>
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<td>12</td>
<td>Finance</td>
<td>Finance and Performance Committee recommendations for control total to be added to forward agenda.</td>
<td>GH</td>
<td>Jan 2018</td>
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Code:
- **Green** – completed
- **Amber** – on schedule
- **Red** – not on schedule
<table>
<thead>
<tr>
<th>Title</th>
<th>SERVICE USER STORY</th>
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<td>CAG</td>
<td>Corporate OT/Nursing Directorate</td>
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| Presenters Attending | Brenda Hibbs – Carer  
Gabrielle Richards                                           |

Brenda Hibbs will be presenting on behalf of her daughter, Bryony. Bryony who attended the Recovery College, went on to volunteer, to teach with SUITE (Service Users in Training and Education), to do the Service User and Carer leadership course and be part of an external expert reference group for Recovery College evaluations. Unfortunately Bryony won't be able to attend as she is now in full time employment! Brenda and Bryony both attended the Recovery College and Brenda will describe her and her daughter’s experiences. She will briefly outline what opportunities they were able to take up, the support they received and what it has meant for them both. Brenda will also reflect on their experiences of care received, the environments they have attended, the difference made by being taught by peer trainers and the hope they both experienced for Bryony's future as a result of coming to the Recovery College.
A- Launch of “Changing Lives”

At the end of November, we launched a refresh of the Trust Strategy under the name, ‘Changing Lives’. This describes what we will do over the next five years to improve patient care and the mental wellbeing of people in our wider communities. We are starting by discussing and exploring the proposed refreshed strategy with our staff, but will increasingly be engaging with service users, carers, families and our wider stakeholders to ensure that everyone has their say.

We have used the name “Changing Lives” because it reflects our belief that we can achieve the most positive impact on our population’s mental health by looking widely at the causes of mental wellbeing, illness and recovery in people’s lives and helping to address them by working in partnership with our staff, patients, carers and local organisations. It builds on many things we have been doing for some time and includes our ambition to broaden our aims to contribute to improving the mental health and wellbeing of the whole population and to improve engagement with our patients and carers.

The Trust’s vision has always been to improve the lives of the people and communities we serve and to promote mental health and wellbeing for all. Changing Lives goes beyond our current focus on the most unwell people in our communities and our specialist services, and aims to contribute to improving the mental health and wellbeing of the whole population that we serve.

This means doing three key things:
• Preventing people from becoming unwell and helping people to stay well in addition to developing and delivering outstanding services
• Innovating in partnership - with staff, service users, their families and carers, and with key partner organisations
Translating our research excellence into clinical practice

By doing all this, I believe that we can make a real difference to the lives of local people and patients, enhance patient and staff experience and provide the best value care for the money we spend. At the core of this approach remains a belief that achieving the highest quality care through the use of quality improvement methods is where our sustainability lies - because the right person doing the right thing at the right time in the right place is always best for our patients and more affordable than the alternatives.

B - Joint Executive meeting across the South London Partnership

We had a successful morning on December 4th bringing together the members of all three senior Executive teams across the South London Mental Health and Community Partnership, i.e. Oxleas, South West London and St George’s and SLAM. The event was kindly hosted by Oxleas and was an opportunity to reflect on the considerable progress that has been made across the Partnership over the last year. In terms of its aims, the South London partnership is about driving a greater borough-based population focus, bringing services and the workforce together across sectors, whilst consolidating specialist expertise and helping to improve accessibility in the community.

We reflected on the particular successes that have been achieved in the first year. These have included the New Models of Care on Forensics which has already resulted in 3,900 bed days being avoided and private sector placements being reduced from 80 to 8 over a comparable six-month period. The CAMHS Tier IV services have delivered 8 additional PICU beds and achieved crisis care funding of £420,000. The Nursing Development Programme has showcased excellent team working across the three trusts and is focused on improving quality of care, creating clearly-defined and consistent career pathways and developing roles to attract people into a lifelong and rewarding career in nursing. Progress has already been made in terms of creating development programmes for each band and securing funding from Health Education England South London.

Looking forward, we will be focusing on the scope for delivering improvements to Adult Complex Care, ensuring that South London Partnership working is seen as “business as usual” and developing an accountable care system for mental health across South London. It was an energising and productive morning that reinforced the substantial opportunities arising from the three trusts working in close partnership together.

C – Avatar therapy for schizophrenia

A research study involving patients with schizophrenia at the Trust has found benefits in using avatars to represent auditory hallucinations. The findings, published in The Lancet Psychiatry, were reported by the BBC and the Independent. More information is available on the Institute of Psychiatry, Psychology & Neuroscience website.
I was delighted to present the very first SLaM star award on Tuesday 5th December.

The work of many colleagues and teams are recognised each year at the annual Staff Awards but we know there are so many people consistently working extremely hard across the Trust who deserve to be acknowledged. With this in mind, we launched SLaM STARS, a new programme designed to recognise and celebrate hard work and achievements on a monthly basis in local teams.

The very first worthy winner was Kieran Quirke, a Band 7 nurse in the Mental Health Liaison Team at Kings College Hospital. This is a highly demanding and pressured role sitting on the boundary of multiple different services each under significant pressure. Kieran was nominated by the whole integrated Liaison Psychiatry Service at Kings College Hospital who described him as “an invaluable colleague and member of the team. His unconditional and unfaltering hard work, compassion, exacting standards, wisdom and expertise truly deserve this award.”

It was a pleasure to surprise Kieran with this award and to hear about his excellent work. My warm congratulations to him and to the nominating team.

Dr. Matthew Patrick
REPORT TO THE TRUST BOARD: PUBLIC
19th December 2017

<table>
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<tr>
<th>Title</th>
<th>Quality improvement update and work plan (including work with IHI) 2017/2018</th>
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<tbody>
<tr>
<td>Author</td>
<td>Dr Barbara Grey/ Lindsay Martin IHI</td>
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<td>Accountable Director</td>
<td>Dr Michael Holland</td>
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Purpose of the paper

1. **Section One**: To provide an update of the progress of QI work in the Trust
2. **Section Two**: Present the work plan with the Institute for Health Improvement (IHI) for year two (October 2017 - September 2018)

The board is requested to discuss and agree work plan with the IHI

Executive summary

This is a joint paper with the IHI. The purpose is to provide an update on current QI work plan, present the IHI overview of our progress and the work plan agreed with the IHI for year two.

**QI team work progress**

The QI team have delivered against the agreed work plan. Key points to note are:

**QI communications.**

There have been some improvements, however there continue to be a number of problems with improving visibility. This is being addressed and the new QI communication manager who commenced work on 11/09/17 is making quick progress.

**Building capacity and capability**

The improvement advisors (IAs) are successfully delivering the improvement science in action training (ISIA) and leadership training and this has significantly reduced the cost of delivery. The feedback and subsequent team QI projects demonstrate the high standard of training. One GP federation in Southwark have taken up the offer of places on the leadership and ISIA training. As demand is expected to increase, a plan will need to put in place to balance the needs of SLaM and partners.

**Progress on trust wide QI initiatives**

The Large-scale initiative for adult acute care (renamed Improving Care and Outcomes - adult mental health(care)) has increased in pace and will be supported by the IHI in 17/18. The 4 steps to safety sustainability plan for inpatient services and the development and implementation of safety
improvements in the community work has commenced. The staff engagement QI plan which was approved by the board in September has commenced with the testing out of change ideas. This work will be linked with the wider Trust engagement work.

**Feedback from IHI visit in September 2017: See Section Two**

**Work Plan with IHI**

We have agreed and commenced a revised work plan with the IHI to enable the Trust to progress the work in the following areas:

- QI team support and additional QI capacity building
- Support for SLaM QI Programmes and Value-Based Health Care- (care process models, large scale initiatives,
- Data Training and Senior Level Mentoring on Use of High Level Data
- Leadership Support

The board is asked to approve the work plan with IHI

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**Section One: Progress against work plan reviewed at the board in June 2017**

Since the last board update in June 2017, the QI team have continued to work at pace to progress the work plan. Outlined below is an update of progress against the work plan followed by priorities for the QI team for the next 6 months.

**QI team recruitment:** We have successfully recruited to three new QI leads and a Communications manager, staff commenced in these new posts at the start of September 2017. We have also recently recruited a team administrator. Secondment opportunities have been offered for internal staff to work as QI facilitators for 12 months. Two people have been successfully recruited and will commence work with the team in November 2107. A secondment opportunity for a QI project manager will be advertised in December 2017.

**Building capacity and capability**

The investment in the IHI improvement advisor training has resulted in the QI team being able to successfully run both leadership training and Improvement science in action training for staff internally. The internal training has been very positively evaluated. It has reduced the cost and the evaluations and QI projects that have been delivered following the training demonstrate that people are applying their learning in practice (see appendix One). To date 313 staff have attended the Improvement science in action (ISIA) training and 111 leaders/ managers have completed “My role as a leader in QI”. The Trust has also trained its first cohort of QI mentors (12). In addition to this, CAMHs clinical QI lead has successfully tested QI awareness sessions (150 staff attended) and 90% of staff said that because of this they would be more likely to sign up for further QI training. The method and findings will be shared with other CAGs over the next two months. A co-produced introduction to QI course starts at the Recovery college this autumn.
The central QI team are working with the CAGs/corporate teams to maintain the enthusiasm and engagement, ensuring that there is sufficient time and resource to enable people to put their improvement skills into practice.

At a review with the IHI on 4.12.17 a decision was made to review the approach to building capacity and capability and a revised driver diagram and measurement plan will be drafted by January 2018.

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**Trust QI Initiatives**

**Improve Care and Outcomes (I care (previously known as LSI))**:

*The aim of Improving care and outcomes in adult mental health is to reduce overall admissions because patients are better managed in their illnesses at home as is appropriate. This will be achieved through ensuring timely access to our services and improving experience of patients and staff. The main outcomes are: 10% reduction in admission and 35% reduction in LOS.*

The collaborative events in May and September 2017 generated nearly 100 projects, and although these linked with a primary driver in the original driver diagram (Appendix Two), some were not clearly aligned with the overall outcomes measures (see chart below). In November 2017 at a review with the IHI we made a decision to review the driver diagram and change ideas and align the QI projects more clearly. This together with integrating the care process model work and continuation of improving safety will enable a more focussed approach in order to achieving the outcomes.
Engagement, participation and Involvement in QI

The principle of co-production is being used in the design and development of all quality improvement projects. The Recovery College has been running sessions within the Quality Improvement training days on understanding co-production and some Quality Improvement projects have involved service users and carers in their inception. Gabrielle Richards has started working with the Quality Improvement team, the EPI central team and the PPI leads in CAGs to develop a clear plan for coproduction in QI. They will be working with service users and carers to develop the draft driver diagram below, which outlines the way forward to embed co-production into Quality Improvement Trust wide. They have identified some change ideas that will be tested.

[Diagram showing driver diagram with primary drivers, secondary drivers, and change ideas]

1. **Primary drivers**
   - Understanding & message
   - Data
   - Resources
   - Frameworks
   - Skills in co-production & involvement (staff, service users & carers)
   - Culture & dynamics

2. **Secondary drivers**
   - Agreement of definitions and message
   - Communication of message
   - Agreement of priorities
   - Message to include other forms of involvement
   - Data collection
   - Data analysis
   - Data use
   - Understanding of data
   - Staff
   - People with lived experience
   - Money
   - Time
   - CAG resources
   - QI team support
   - Linking of existing frameworks
   - Use & awareness of existing frameworks
   - Developing new skills
   - Recruiting/Finding those with existing skills
   - Retaining those with existing skills
   - Managing the change of context in relationships
   - Celebrating & promoting good practice
   - Promoting co-production as the “gold standard”
   - Seniors in the trust modelling good practice

3. **Change ideas**
   - Develop a common strategy
   - Co-producing some PEDIC questions
   - Data dashboard
   - Time limited support for IR to recruit QI interested cohort & process their applications rapidly
   - Developing a database for IR
   - More induction & support for those on IR
   - Increased IR budget
   - Central pot of money to support teams to pay/renumerate SU/carers
   - QI project to reduce variability in wait time to join IR
   - QI team to hire persons with lived experience to model behaviour
   - Co-produced/co-delivered training for SU/carers/staff
Communication and engagement plan

The QI communication and engagement plan presented in the last board paper (June 2017) is in place and progress has been slow. The QI team had its first QI campaign “ask me about QI”. ran for the month of October, and our learning from this one will inform future campaigns. The new communications manager is now in post and the QI team will now take the lead role in QI communication. The first QI wall is due to be in place by January 2018. The staff diagnostic work reported to the board in September as part of the work to develop the aim and driver diagram to improve staff engagement has also helped to raise the profile of QI. Do follow us on Twitter, @SLAM_QI.

QI Engagement with Partners

We have offered places on the QI training for primary care and CCGs and have had attendance from Southwark GPs and practice managers. Southwark GPs have requested further places in the coming year and we are working with Lambeth CCG to open up places for their practices. As part of the SLP, places have been offered to Oxleas mental health trust. We regularly meet with QI counterparts within the South London Partnership and are starting to develop joined up QI programmes across the partnership as well as sharing learning.

Senior leadership quality and safety walk round review

Following the tests of change completed over the summer and in discussion with board, executive members and staff, a new plan is in place to start in January 2018. The aim is to achieve a more consistent approach to the walk rounds, improve the administration, increase the number of teams who have visits and test a more robust and reporting and measurement method.

Developing as a data intelligence driven organisation

The QI team are working in conjunction with contracts and performance and the programme management office (PMO) and services (clinical and non-clinical) to develop and improve the consistency and accuracy of data so that teams can use the data to inform their decision making and improvement work. The third test of change for the QI dashboard was developed in September and this will be tested again at the Quality matters meeting on 24.10.17. This work will increase in pace in year two with the support of the IHI (section two)

Priorities for the next 12 months for the QI team

1. Complete QI recruitment
2. Ensure work plan proposed with IHI is executed so that the agreed objectives are achieved in the next 12 months (section two)
3. Maintain the progress to build the capacity and capability in the Trust in QI methodology including new training with the Recovery College and governors
4. Support people to more explicitly align QI activity to the Trust’s overall quality improvement plan
5. Develop and implement plan for coproduction for QI
6. Agree a framework with CAGs to continue to build capability and report progress on QI
7. Support corporate departments to become more actively involved in QI in their services as well as with clinical services
Section Two IHI report

SLaM has been steadily working to enhance the quality improvement capability across all dimensions of the Trust. While much of the work of the past year was focused on building that capability, much of the work of the upcoming year will be focused on putting that capability into practice centred on core strategic initiatives. This report provides an overview and more detailed work plan in Appendix One.

Recognising the changes that have already taken shape

While the more obvious changes have been discussed in past reports (such as trainings, QI chartered projects, and the beginning of some project based outcomes), the gradual shifting of the trust has been less well articulated. It is this gradual shift of being an organisation with a pervasive base of improvement that signals real change across the institution. For example, recently the Human Resources department reached out to the QI team for additional guidance on using QI to help drive their aim of having a joyful workforce with staff consistently having an excellent experience. It is a very encouraging signal to have departments, outside of the direct scope of the initial QI work, reach out based on communication from colleagues.

Another example of the gradual change is the enhanced QI role the CAG Service and Clinical Directors are assuming. Based on a test in CAMHs over the past seven months, where a consultant psychiatrist and deputy service director have taken stronger responsibility for helping to direct and support the focus of the QI work, other CAGs are testing the use of embedding the responsibility within a role over the next four months (December 2017 - end of March 2018) with support from the QI team. This is a positive signal that the work of continuous improvement lies with those making the changes with the strong support of the QI team rather than the QI team making the changes.

Creating an Overall Organisation-wide Leadership Dashboard

With a lot of preparatory work to understand the current state of data collection and measures in the SLaM, a multi-disciplinary group met on 22 November 2017 with Lindsay Martin, from IHI, to draft an organisation-wide Leadership Dashboard. There was representation from the SMT, Finance, Clinical Informatics, Business Intelligence, Contracts and Performance, and Quality Improvement. In addition, apologies were sent from Nursing and Human Resources and subsequent conversations have taken place to include their perspective. The aim of the group was to draft a high-level set of system measures that will be used by senior leadership at SLaM to be knowledgeable about current performance, identify system-level aims, understand gaps and consequently begin conversations to direct strategy and resources. The group agreed that all measures must have the following four characteristics: Meaningful, Understandable, Simple, and Consistent.

Out of this meeting came a strong proposal of measures that is being mocked-up to test with Leadership in late January with expected discussion with the Board in February. Along with this dashboard, a set of Operational Rules are being drafted to articulate how the measures are intended to be used by the SMT at SLaM.
Progress on Care Process Models and Additional Focus on Value

The Large-Scale Initiative for adult acute care now renamed Improving care and Outcomes – Adult mental health (I Care) has increased in pace and will be supported by the IHI in 17/18. The focus for the past several months has been organising the many projects that are currently underway into clear work streams that are tied to the overarching mission of SLaM. The major areas of work will include:

- Four Steps of Safety, Inpatient
- Four Steps of Safety, Community (work commenced on 27.11.17)
- Operational inpatient Care Process Model
- Diagnostic Care Process Model

Four Steps of Safety (Inpatient) was initiated in 2015 and therefore is in a further state than the other three. Progress across the board with this change package is being assessed and then a further implementation and spread plan is planned.

Four Steps to Safety, Community; Acute inpatient operational Care Process Model, and the first diagnostic Care Process Model all require content creation, prototype testing, and pilot testing. Jonathan MacLennan will be supporting the QI team work and in addition to support from John Boulton (LSI Improvement Advisor) and Lindsay Martin (Director of IHI/SLaM Contract), Kathy Luther and Lucy Savitz (both experts in Care Process Models and content creation) will play key faculty roles. This work will progress methodically over the course of the next year, with the following expected pace:

- Months 0-4: Development of CPM or Change Package based on strong evidence, fully articulated with operational definitions and rationale noted. Measurement strategy in place to know the changes are leading to improvement.
- Months 4-7: Initial prototype testing and modification of CPM if appropriate
- Months 8-12: Pilot Testing in wards across all four Boroughs with early results in process measures leading towards results in outcome measures.

Aligning with the sentiment of the system measures work that was referenced earlier, the measures required for tracking progress of the LSI will also maintain the four characteristics: Meaningful, Understandable, Simple, and Consistent.

As this work progresses and is firmly in place, we will be able to introduce some further value-based work that has been newly tested (with strong success) through IHI’s Innovation Process. This work focuses on value management at the front line. We expect to be able to further discuss this work with SLaM in the late spring / early summer.
Additional Work with IHI

- Supporting the QI team: there will be regular mentoring sessions with the SLaM QI team to focus on opportunities for strengthening QI skills.
- Supporting development within SLaM of specific QI skills: Example includes data and measurement training.
- Leadership team support: Around the implementation of the new dashboard and the ongoing Leadership Challenges of being a continuously improving organization.
## Proposed work plan with IHI

<table>
<thead>
<tr>
<th>Element</th>
<th>Activity</th>
<th>Output</th>
<th>Outcomes October 18</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Element 1: QI Team Support and Additional QI Capacity Building</strong></td>
<td>Sessions will be a combination of learning events by IHI team and presentation of successes/challenges by SLaM QI Team with discussion and mentorship. Working with the SLaM QI Team to create specific learning sessions for Trust staff to enhance skills to execute Trust-wide initiatives.</td>
<td>Support of SLaM QI team in the Science of Improvement and QI project management including building additional skills, providing support and mentorship, and facilitating learning among team members.</td>
<td>The QI team demonstrate their skill and knowledge in enabling successful delivery of Trust wide QI programmes of work.</td>
</tr>
<tr>
<td><strong>Element 2: Data Training and Senior Level Mentoring on Use of High Level Data</strong></td>
<td>Measurement Workshop for 20 people, 2 days on-site, any materials needed for training. Development of SLaM Executive Measurement Strategy with senior leaders and managers (November 2017).</td>
<td>Business managers are better able to use and understand data for improvement and measure progress over time. SLaM Leadership Team is aligned on SPC. The system of measurement contributes to the overall strategy of improvement at SLaM. Selection of high level measures to gauge overall performance of SLaM.</td>
<td>Visible evidence that data is reported and used at team level using run charts and SPC charts to inform clinical decisions and improvements. Visible evidence that newly agreed upon Executive Measurement Strategy (that is being developed) is being used to guide decision making at the Executive Level and the informatics system is reliable.</td>
</tr>
<tr>
<td><strong>Element 3: Leadership Support</strong></td>
<td>SMT bi-monthly coaching calls (including Walk Around Support to start). Leadership's use of Data for improvement - 1/2 day workshop on-site with wider Executive Team (about 25-30 people). Annual deep dive- final one in Autumn 2018: 1 day of site visits, 1 day of joint planning and design.</td>
<td>Leadership at SLaM understand and support the work of the QI team and partnership with IHI. Leaders continue to conduct Walk Aroun ds systematically and the information gathered during Walk Aroun ds is shared with point of care staff and SMT. Leaders understand their role in the use of practical data for improvement. IHI team has a deep understanding of ongoing work and progress. IHI and</td>
<td>Evidence from team meeting minutes, conversations and feedback from staff and others that the senior team are modelling QI leadership behaviours. Demonstrable improvement in QI projects demonstrating improvements in quality and cost, leadership modelling QI.</td>
</tr>
<tr>
<td>Weekly review and planning/challenging/support calls</td>
<td>SLaM teams have dedicated time to co-design future work together</td>
<td>Tipping point achieved (20%)</td>
<td></td>
</tr>
</tbody>
</table>

| **Element 4: Support for SLaM QI Programmes and Value-Based Health Care** | **Improving Care and Outcomes (previously named Large Scale Initiative Adult Mental Health):**
-Quarterly in-person learning sessions, monthly virtual calls with teams, every other month in-person support and ongoing virtual support
-Creation of Care Process model for Adult Mental Health: design, prototype, large pilot in multiple wards across all four Boroughs | Initial wards are moving towards achieving results in outcome measures, and have demonstrated improvement in process measures for work already underway from year 1. Creation of care process model for adult mental health, outcomes in prototype wards, initiation of pilot testing in wards across all Boroughs with data collection and process measure improvement beginning. |

| **Large Scale Initiative: 4 Steps of Safety:**
-Inpatient: Adult Mental Health (will be reviewed as part of the Adult Mental Health Acute Care) - focus on spread to all wards and sustainability within wards already embedded;
-Inpatient: Older Adults, Child and Adolescent Mental Health, Forensic | Spread process has started of successful change. For Care Process Model (CPM) for acute inpatient care and a Segment of Schizophrenia Care:
Months 0-4:
-Development of CPM based on strong evidence, fully articulated with operational definitions and rationale noted
-Measurement strategy in place to know the changes are leading to improvement

Months 4-7:
-Initial prototype testing and modification of CPM if appropriate

Months 8-12:
Pilot Testing in wards across all four Boroughs with early results in process measures leading towards results in outcome measures. |

| For Inpatient: Demonstrates reduction in violence and aggression in inpatient wards by 50% from baseline from 2016 |
| continued support for those who have initiated, spread to new wards, creation of a sustainability plan, modification of approach to be appropriate for local wards (in particular CAMHS) | prototype and pilot wards, improvement in process and outcome measures Community: creation of solid change package for community changes. Process level changes in pilot units. Beginning of spread plan. | -At the end of 12 Months -Full completion of QI training -Modification of interventions to be appropriate for CAMHS, Forensic, Other Psych Medicines -Overall 50% reduction in violence from baseline data. Demonstrates consistent use of interventions to sustain best practice. For community safety intervention (CSI). There will be evidence that staff and service users and carers have been engaged, content of interventions developed and tested in all areas For Inpatient: |
| Community: Creation of content, prototype and pilot testing across all services in SLaM | Decisions at SLaM are guided by the use of data for improvement. Ongoing monitoring for data for quality assurance, quality improvement and quality planning is routine. Outcomes data is linked to cost data with the intent to deliver value-based care for all service users. | Quality and cost data will be linked routinely to be able to demonstrate not just improvement in patient and staff outcomes but also delivery of value-based care - tying financial data to the outcomes achieved. |
| Continued support for SLaM to become a data-intelligent driven organization focused on data for monitoring, improvement, and value-driven care | | |
Number of staff trained to date: 313/480 (65%)

As a result of the training, we currently have over two hundred projects working towards the Trust’s four priorities which are patient safety, patient experience, staff experience and clinical effectiveness.

Projects vary from improving patient experience by increasing engagement on Gresham 1, improving out of hours CAMHs staff experience at University Hospital Lewisham, and improving the waste rooms and disposal processes at Ladywell Unit.

Please see appendix Three for further examples, including; reducing psychology assessment waiting times in Croydon Perinatal Services, and improving the customer experience within the Trust from a Digital Services perspective.

Four Steps to Safety was implemented across 48 inpatient wards in SLaM between 2016 and 2017. There have been improvements in terms of reducing violence and aggression on some wards. For example, violence and aggression rates on Effra Ward ranged between 1 and 5 incidents per month. Effra ward started using the four steps to safety interventions in January 2016. Between September 2016 and June 2017 there have been zero incidents of violence and aggression reported.

Please see Appendix Four for data from some wards that were successful with the implementation of the four steps and reducing violence and aggression.
Evaluation of ISIA training has been very positive

My Role as a leader in QI

11/160 (69%) leaders and managers have attended. All evaluations have been very positive since the programme has been run internally, with 100% scoring 4 or 5 (very good to excellent). Participants made commitments to support teams back in the work place and feedback from staff suggests that this is happening in practise.
**AIM**

Our aim is to reduce overall admissions because patients are better managed in their illnesses at home as is appropriate.

This will be achieved through ensuring timely access to our services and improving experience of patients and staff.

The main outcomes are:
- 10% reduction in admission
- 35% reduction in LOS

Balanced budget by December 2018

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**Primary Drivers**

- Unplanned admissions
- Effective teamwork within and across boundaries
- Patient experience
- Staff experience
- Patient transitions through discharge

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**Secondary drivers**

- Care planning
- How community teams work
- Access to services
- Primary care systems
- Communication across pathways
- Transparency and openness
- Training
- Information and data
- Communication
- Collaborative working
- Safety
- Environment
- Collaboration/collaboration
- Continuity of care
- Trust systems/Wider systems
- Training
- HR
- Environment
- IT
- Safety
- Housing and social care
- Timely and expected
- Continuity of care

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**Current change ideas**

(associated with four boroughs)

- A and L – training in formulation of risk
- Discussion of formulation at weekly team meeting
- A and L – access to AOD dashboard to prioritise cases to support flow
- PR1 – reviewing the use of amber zone to identify potential social care needs early
- Inpatient – using electronic ward allocation to smooth patient flow
- Crisis line – involving service managers in the development of crisis provision and services out of hours
- HHH – attend weekly meetings with PRT
- Inpatient – identify unknown patients within 7 days and allocate for coordinator
- Inpatient – using conference calls into ward rounds if care coordinators unable to attend
- HTT – communicates to inpatient and community team when patient admitted, the purpose of admission and identify obstacles to discharge within 24 hours
QUALITY IMPROVEMENT PROJECT FOCUS

What are we trying to accomplish?

To improve the customer experience within the Trust from a Digital Services perspective

What change can we make that will result in an improvement?

- Answering more of your calls, more quickly
- Resolving more tickets within SLA
- Improving communication from Digital Services around the Trust

What change ideas are we testing?

- Improved training and knowledge sharing
- Improved communication
- High focus on SLA targets
- Asking for your feedback

Service Desk Call Answer % - July 2017

Calls Taken: 3953
Calls Answered: 3686
Total Answer %: 93.2%
Quality improvement projects of the week

Reducing psychology assessment waiting time in Croydon Perinatal Services

90% of service users to be offered a psychology assessment appointment within six weeks of acceptance of an appropriate referral by August 2018

PDSA Cycle Strategy

- Monitor number of people waiting on 1st day of each month
- All psychology start to enter draft of first assessment report
- Use data format and add missing if variable waiting times automatically
- Add new columns to database eg: name referral accepted, date first app offered
- Generate reports of capacity, demand and waiting time (planned)
- Identify admin support for writing letters (planned)
- Letter sent routinely to all accepted referrals
- Template letter drawn up and stored in shared folder
- Monitor data for individual boroughs as well as trust-wide
- Establish best way to separate data for each borough (either in separate tables)
- Adapt: creates database to be compatible
- Database including referral: maternity, mental health and social work

Run chart comparing number of total referrals, referrals accepted, and number of assessments

Run chart of average waiting time from referral to assessment appointment offered (days)
REPORT TO THE TRUST BOARD: PUBLIC

28th November 2017

<table>
<thead>
<tr>
<th>Title</th>
<th>Inpatient safe staffing annual report to the Board</th>
</tr>
</thead>
<tbody>
<tr>
<td>Author</td>
<td>Amanda Pithouse, Deputy Director of Nursing and Joanna Bradley, Senior SLMH&amp;CP Workforce Development Nurse</td>
</tr>
<tr>
<td>Accountable Director</td>
<td>Beverley Murphy, Director of Nursing</td>
</tr>
</tbody>
</table>

Purpose of the paper

The paper is provided to assure the Board that inpatient staffing establishments are sufficient to meet clinical need and to assure the Board that the Trust is meeting its obligations to assess the safety and suitability of inpatient nurse establishments as set out by the National Quality Board.

Executive Summary

The Chief Nursing Officer and the National Quality Board set clear expectations (2013) about the need for health providers to regularly assess the suitability of inpatient nursing establishments. The expectation includes the use of evidence based assessment tools where they are available and also the consideration of clinical hours per patient day. For mental health there is no agreed methodology or evidence base and the clinical hours per patient day is not yet in place. An important part of the requirement is that provider Boards receive an annual report with six-month follow-up reporting, this is in addition to the monthly public reporting of breaches.

During October 2017, the Director of Nursing led a process that looked at a number of data sets for each of the inpatient wards. The data included % of vacancies, sickness, use of temporary staffing, incident rates and complaints. The data was used to develop a conversation which using professional judgment aimed to conclude if the current nursing establishment is sufficient to deliver safe care. It was concluded that all establishments were sufficient.

However, the needs on inpatient units can change very quickly and professional judgment was also used to establish if there were escalation procedures in place and what nurses would do if the presenting clinical needs could not be met by the available establishment. The Director of Nursing was satisfied that there are clear structures and processes to enable escalation.

The process used was new and identified opportunities to further improve the use of available resource. The process also confirmed that whilst the Trust recruitment activity is improving staffing, more work is needed to retain staff.

It is recommended that the Board of Directors:

a) Notes that the Trust is meeting its obligations to assess the safety and suitability of inpatient nurse establishments as set out by the National Quality Board;

b) Accepts assurance from the Director of Nursing that the inpatient nurse staffing establishments are sufficient to meet clinical need;

c) Delegates authority to the Quality Committee to consider the 6-month follow up report.
INPATIENT SAFE STAFFING – annual report to the Board

1. Purpose

The purpose of the report is:

a) Assure the Board that there is good oversight of inpatient staffing establishments.

b) Assure the Board that the Trust is meeting its obligations to assess the safety and suitability of inpatient nurse establishments as set out by the National Quality Board.

2. Introduction

The Safe Staffing initiative is part of the NHS response to the Francis Report, which called for greater openness and transparency in the health service. Following a requirement from the NHS Chief Nursing Officer England from April 2014, it became a national requirement for all hospitals to publish information monthly regarding nursing staff levels. South London and Maudsley NHS Foundation Trust meets this requirement by reporting into the national Ulysses system and also as a part of the Quality, Effectiveness Safety Trigger Tool (QuESTTT) which is presented monthly as a part of the Chief Operating Officer Board Report. The National Quality Board (NQB) document, ‘How to ensure the right people, with the right skills are in the right place at the right time’ sets out the requirement for provider Boards to ensure there is an annual strategic staffing review with a report each six months.

Safe staffing is complex and has to take account of multiple factors such as patient and clinical need, skill mix, recruitment and retention, clinical activity and acuity and other professional groups’ activity. There is no evidence base or agreed methodology as to the approach to a staffing review in mental health services.

3. Background

The Chief Nursing Officer (CNO) for England with the National Quality Board (NQB) and the Trust Development Authority (TDA), produced guidance in December 2013 for Trusts which sought to support organisations in making the right decisions to create supportive environments where their staff are able to provide compassionate care. This report identified the themes, expectations, process, actions and leads.

The key priorities are:

- monthly workforce reporting to the Trust Board
- six monthly establishment reviews
- displaying planned versus actual staffing numbers in clinical areas
- publication of monthly workforce data

4. Safety of Staffing at South London and Maudsley NHS Foundation Trust – methodology October 2017

Guidance in 2017 from NQB and National Health Service Improvement (NHSI) advises a flexible, pragmatic approach to safe staffing, using evidence-based tools where available. It goes on to state that Trusts should use flexible staffing strategies, triangulation and comparisons with similar teams and services. It recommends the implementation of Care Hours Per Patient Day (CHPPD) in acute and community hospitals and that Trusts develop a local quality dashboard for safe sustainable staffing.
In the absence of a consistent and agreed methodology for mental health, the Trust has published breaches of planned vs actual staffing but not cause and effect. Numbers have been published with some narrative but little context. The QuESTT indicators, when grouped together, describe in a dashboard style the most important conditions necessary for a well-functioning inpatient ward. South London and Maudsley NHS Foundation Trust has piloted a new staffing review methodology to elicit a variety of data sets over time including QuESTT, staffing breaches, vacancy rates, incidents, sickness rates, serious incidents and complaints. An example of the data set is at appendix 1.

The Director of Nursing met with each of the Clinical Academic Group (CAG) leads to review staffing data per ward and through discussion identified emerging themes. The conversations were guided by professional judgment. The purpose of the review is to determine if current establishments are sufficient to meet need and to determine the approach to managing resource in times of greater challenge and/or increased clinical need. Staffing issues identified in the discussions are outlined below.

5.1 PMIC CAG overall picture
The overall picture for the CAG shows an improvement over 6–12 months, with stabilising and improving QuESTT scores and reductions in breaches following a difficult year with nursing recruitment and retention. Senior Leaders are evidently cited on issues and are supporting teams to manage area of highest concern.

EDU: Within the EDU, there are ongoing concerns regarding morale; senior leads are addressing this. Staff establishments are under review to facilitate the inclusion of associate practitioners.

Lishman: Lishman is in the best place it has been in a long time despite a more challenging client group in the last 18 months. There have been enhanced observations due to acuity and risk of falling.

MBU: Breach rates remain high due to the need to deploy staff to care for the babies and Court-directed parenting assessments.

Sickness and Vacancies
Overall sickness is improving within the CAG, however two wards (EDU and Lishman) still have some issues regarding staff off on long-term sickness. EDU had a high use of bank staff following a high vacancy rate: nine band 5s left within the last year. However, the ward is currently in a good position with only two vacancies remaining. Lishman has a history of high vacancy rates however; active recruitment has resulted in six vacancies being filled.

5.2 Psychosis CAG overall picture
The Psychosis team presented a well thought through data set. Overall, the trend for most wards was towards improving QuESTT scores and a reduction in breaches with only one ward where this was not the case. It was recognised that there is still much work to do to continue improving, but this exercise identified opportunities as well as areas of need. Sickness management was identified as a priority area as well as better management of roster and annual leave.

Westways: Westways was noted as having a much-improved picture; strong leadership and clear management has equated to low breaches, vacancy rates and sickness. Grievances and performance are actively managed and high-quality care delivered despite staffing levels being significantly lower than other units.

Heather Close: QuESTT scores healthy but some anomalies requiring further investigation and the establishment is currently under further review due to changing needs and available
resources.

**FM2/NPU:** QuESTT improving but needs a close ongoing review due to ongoing breaches.

**LEO:** QuESTT high breach in February 2017 due to impact of serious incidents and high levels of observations.

**THU:** Staffing breaches at 40% reported to be due to high vacancy rates and part-time staff due to secondments. Three Band 5 nurses on long term sickness and one Band 5 acting up, leaving four Band 5 posts unfilled by regular staff and high observation levels and acuity. Four registered nurses are due to commence in January 2018. Other high QuESTT scores and breaches were correlated to enhanced observations due to acuity and clinical need. However, this is not reflected in Datix reporting. Datix reports and severity of incidents were low despite being a challenging behaviour unit, which may suggest a pattern of underreporting. Discussions related to a high tolerance before formal reporting, with reports only being completed for actual assault and not reporting enhanced observations. The Deputy Director of Nursing will focus on this ward and feed back.

**NPU:** reported QuESTT breaches related to high levels of enhanced observations and assaults during the period. However, given the nature of service and numbers of enhanced observations etc. Datix reporting is low potentially pointing to underreporting.

**Sickness and Vacancies**
Heather Close has a number of long-term sick especially with redeployed staff which needs further investigation. NPU and THU also demonstrate relatively high levels of sickness which could correlate with breaches due to high vacancy rates.

LEO has a high breach rate due to high vacancy rates however the trend is improving due to active recruitment. The national psychosis unit has unsustainable vacancy rates with twenty shifts per week that cannot be filled by substantive staff. However, at the time of assessment there was an improving picture with a permanent ward manager in post.

**5.3 B&DP CAG overall picture**
There have been challenges with recruitment and retention of staff which has been mitigated by strong senior nursing leadership and a clear model of care. QuESTT scores are not always representative of the level of need, due to staff flexibility and commitment to the services within which they work. The CAG is innovating with workforce development planning, creating Band 8a and Band 4 posts (Assistant Practitioners) within the workforce to reduce over-reliance on bank and agency staff and goodwill and over-dependency on individuals. The CAG also recognised sickness as a matter of concern which is not unusual in forensic services.

**Spring:** is recognised to have undergone a difficult time with high acuity and assaults on the ward. This has correlated to high sickness rates and poor retention of staff. However, breaches are reducing and QuESTT seems to be more predictable with a new ward manager in post and active recruitment taking place.

**NAU:** enhanced observations and acuity of client need correlate to high QuESTT scores and some breaches, with 150 shifts showing patients on enhanced observations over the last six months. Two patients on enhanced observations are funded by CCGs and one patient in CUH on 1:1 for a year. Therefore, there have been unusual demands on service exceeding capacity. The management team has full oversight of the issues.

**Waddon:** has had a number of challenges over the year with the retirement of an established consultant; a new ward manager in their first managerial post; a challenging
client group; the need to manage patients’ attempts to access illicit substances and a safeguarding concern resulting in a temporary destabilising effect on the ward. Senior level support has been implemented including a redevelopment of the workforce resulting in a Band 8a post to support the nursing team.

**Thames:** There is new clinical leadership on the ward, active recruitment with retention plans and innovative workforce development plans, such as the introduction of Band 4 (Assistant Practitioner) roles within the team to support the team and clinical practice.

**Addison HMP Wandsworth:** Recruitment remains a challenge with 33% Band 5 and six vacancies. There were seven recruitment cycles before an appropriately skilled ward manager could be appointed. By January 2018, all vacancies will be filled, which has been possible due to the drive and judgment of the service manager.

**Sickness and Vacancies**
Norbury sickness is above Trust average but is in process of being managed. River House now has a vacancy rate of ~10% for registered nurses.

NAU QuESTT scores and breaches do not reflect the issues at ward level as leaders will step down to fill breaches and support the team, the tendency to over rely on flexibility within the team and individuals is unsustainable over time. There is over recruitment of Band 3s to cover and support.

### 5.4 ACUTE CAG overall picture
During this review, eleven wards were reviewed and discussed in detail, the remaining wards are being picked up in the agency review process. High acuity and clinical need was recognised as a dynamic factor for less stable QuESTT scores and overall it was recognised that many acute and PICU wards have been challenged over the previous year. Recruitment challenges and sickness levels are ongoing difficulties and therefore active recruitment to posts remains a priority for the CAG. At the time of writing the band five vacancy rate was <18% which is manageable and much improved.

E-roster, management of shifts and annual leave could be improved. A strong, clear leadership model and models of care have been recognised as a factor in improving performance, workforce development plans are being implemented with the addition of Matrons and Clinical Nurse Specialists.

There was a discussion about the risk of looking purely at QuESTT scores as these do not always reflect the reality on the frontline an example being Gresham 1 with low breach rates and QuESTT scores but also low morale and high sickness.

**Clare:** The QuESTT data gave a mixed picture; breach rates seem to be improving and are relatively low. The breaches are related to staff sickness as the team is fully recruited to and again with low turnover of staff.

**Eden:** QuESTT scores are improving and breaches are low, however staff morale is also low. There have been a number of challenges including a serious work-related injury, significant sickness rate and a staff death (unrelated to the workplace). To support staff, bed numbers were reduced from 12 to 10. The team is being supported by a new Clinical Service Lead (CSL) and a new Matron.

**ES2:** This has been a challenging year for ES2 with QuESTT scores deteriorating and breach rates up to 50%. Sickness rates and vacancy numbers are low with the scores attributed to significant changes on the ward during this data period. The team report a greater proportion of patients with dual diagnosis and other clinical challenges impacting on
the ward environment and milieu. There is currently no data to evidence this, so further data such as Datix, enhanced observation numbers, diagnosis will be looked at. The ward is also currently piloting a new model of working with twilight shifts and this will be reviewed in three months.

**Johnson PICU**: QuESTT is high and unpredictable over period reviewed. There were concerns regarding high levels of sickness on the unit correlating with high acuity and incidences on the ward. Johnson ward is described as 'busy and disturbed', therefore discussions moved beyond an establishment review. There are also issues regarding roster management with a number of staff on fixed patterns.

**John Dickson**: QuESTT scores are high peaking with breaches up to 60% currently reducing each month. Staffing vacancies do not seem to be a problem, but roster management may be of concern.

**Gresham 1**: QuESTT and breaches do not completely reflect the picture on the ward. Sickness levels are high and there have been significant problems in recruiting and retaining staff. There has been a high-level use of bank staff which has reduced the breach rate. There is a new manager in post and the leadership team is being supported by the CSL, incoming CNS and Matron. Supportive systems including training particular to the needs of the client group is planned, including Emotionally Unstable Personality Disorder and self-harm.

**Sickness and vacancies**
Due to the sustained recruitment efforts the vacancy rate is at its lowest for 12 months. Sickness management needs to be in place consistently.

**5.5 MHOAD CAG overall picture**
The overall picture was mixed with some wards presenting a stable trend of relatively low QuESTT scores and breach rates, but others such as Chelsham, Greenvale and Hayworth with less predictable and less favorable scores. These services reported a number of challenges early within the period with high staff vacancies, difficulties with recruitment and changes with working practices. However, the trends are improving and stabilising with many dedicated staff, improvements in managing sickness and developing strong leadership models.

The CAG has benefitted from active recruitment with correlating reduction in use of bank and agency staff. The CAG is actively involved in the development and training with emphasis on band 2-4 development roles, modelling pilot wards for the Assistant Practitioner (AP) role, and the Multi Professional Team (MPT). Strong leadership with clear models of practice has been recognised as integral to ensuring high standards of care. The vacancy rate for band 5 nurses has fallen below 10% with a number of students requesting jobs on older people’s wards.

**Greenvale**: QuESTT scores are rising related to a need for enhanced observation. It had a number of high breaches early within the period related to high vacancy and low recruitment rates combined with high sickness levels putting pressure on the service. This is now improving.

**Hayworth**: had favourable QuESTT scores and breach rates but has become less predictable although trending again towards improvement and a more stable position with strong clinical leadership in place. There have been a number of changes to the ward during the period under review such as some long-term sickness, retirement and maternity leave which impacted on the stability and continuity. The CAG is confident that the picture is of a stabilizing, improving ward.
Chelsham: had a high number of breaches over time although QuESTT scores remain low. It has poor staffing levels and was reviewed after Care Quality Commission (CQC) results. There have been some innovative developments in practice and staffing with development of Band 2-4 roles, specialist services such as speech therapist in post and therapy enabler, a strong emphasis on MPT working. Sundown hours have been built into the establishment to cover meal times. Chelsham has a plan to implement three band 4 Assistant Practitioners early in 2018.

Sickness and vacancies
Improving and being well managed.

5.6 CAMHS CAG overall picture:
Overall the CAG is looking at an improving picture with reducing QuESTT scores and breaches, but is not without ongoing challenges. Sickness levels have been fairly stable within the low range across the CAG and those areas of concern are being supported to actively manage sickness. The senior leads team are sighted on issues of concern and are fully engaged in ensuring standards of care are retained. QuESTT data is improving with a corresponding reduction in breaches however; there remain some hot spots related to acuity of the client group resulting in a temporary reduction of beds to support teams.

Active recruitment and over-recruitment has resulted in reducing vacancy rates but the Kent wards remain difficult to recruit to with a fast turnover of staff in many areas. Therefore, the CAG is also working on retention by investing in development and training programmes such as Band 5 Preceptorship, Band 5-6 development roles and programmes and investing in Band 4 assistant practitioner roles. There is also a focus on succession and workforce planning with over investment in areas despite cost pressures to support training, leadership and development of new roles.

Acorn Lodge: Recruitment and retention remains a problem for Acorn Lodge with historically high vacancy rates, however this is currently not within the registered workforce where recruitment and retention is good but within the unregistered workforce where turnover is high. This is currently being managed by a rolling programme of recruitment every three months. The use of bank staff can be problematic due to the nature of the client group.

Snowsfield: Over the last 12 months there has been a high turnover of staff, with four newly qualified Band 5 staff leaving within six months of registration thought to be due in part to lack of support from experienced staff. Learning has been taken and the new cohort of staff are being intensively supported. QuESTT data and breaches are improving and ward currently feels contained with positive attitude within the staff team and is working to return to full capacity.

BAU: has been unsettled with QuESTT data high, there have been a number of issues causing these, notably patient acuity with two patients requiring PICU within the time monitored and one serious incident of deliberate self-harm causing considerable concern. The unit has a reputation for managing difficultly well.

Kent Wards Oak and Ash: there have been some peaks within the data with breaches due not only to high vacancies but also some patient acuity; this has been clearly documented through Datix with management clearly reviewing and managing incidents and good staff relationships and support. Kent remains a difficult area to recruit to, however the unit is currently in the best place it has ever been with sickness low and good staff engagement however it will continue to need support from senior leadership.
Sickness and vacancies
Sickness rates across CAHMS are historically below average and well managed. The current challenge for vacant posts relates to the Kent based inpatient units – a full recruitment plan is in place.

6.0 Summary and conclusions

The methodology piloted in October 2017 offered a rounded view of staffing issues and how the issues relate to a number of quality and safety indicators. Although time consuming, all CAGs reported the annual review as useful and the Director of Nursing gained a full understanding of the challenges and how they might compromise care. The process provided objective challenge and oversight of local working arrangements.

All CAGs reported establishments that broadly meet clinical need and were also able to set out how establishments could be flexed and issues escalated in times of increased clinical need. The use of bank and agency staff correlated to vacancies, sickness and known increased acuity.

Although the Director of Nursing is assured that establishments are sufficient, the process also identified opportunities to be more flexible with establishments to support the implementation of band 4 Assistant Practitioners and in the future Associate Practitioners. This would reduce reliance on difficult to recruit band 5 registered nurses, offer an enhanced career pathway for band 4 staff and protect the quality of care. This work is more developed in some CAGs than others.

The challenges with recruitment, although much improved, do remain. We have clear evidence we are able to recruit, the continued focus on retention strategies is of great importance if we are to protect the quality of care. Sickness management remains an area for improvement as does the use of e roster to improve resource management and transparency.

A similar process for community services will be adopted.

7.0 Recommendations

It is recommended that the Board of Directors:

a) Notes that the Trust is meeting its obligations to assess the safety and suitability of inpatient nurse establishments as set out by the National Quality Board.

b) Accepts assurance from the Director of Nursing that the inpatient nurse staffing establishments are sufficient to meet clinical need

c) Delegates authority to the Quality Committee to consider the 6-month follow up report.

Amanda Pithouse
Deputy Director of Nursing

Joanne Bradley
Senior SLMH&CP Workforce Development Nurse

Beverley Murphy
Director of Nursing

8th December 2017
Total breaches from April 2014 - April 2017

Total sickness from April 2014 - April 2017

Total vacancies April 2014 - April 2017

Quality Data

- ST's over six months
- Complaints over last six months
- Quest scores over last six months
- Hospital acquired: pressure ulcers
- Hospital acquired UTI's
- Number of people on enhanced observations

Analysis: What is the current situation, what has been the impact on the wards, action plan
Title: Q2 report Lessons Learned

Author: Lucy Stubbings, Head of Patient Safety

Accountable Director: Beverley Murphy, Director of Nursing

Purpose of the paper

(1) The Q2 Lessons Learned report provides details of the activity and key lessons arising from incidents, complaints, claims, Central Alerting System (CAS alerts) and Inquests.

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

Executive summary

It is good practice to report and learn from all adverse incidents; it is generally recognised in the NHS that accurate reporting and learning from incidents is driven from a healthy and open culture. NHS Trusts are also regulated to report adverse incidents of all kinds. The Board of Directors receives a quarterly update on adverse incidents, which includes summary information about some of the themes of learning and also performance data. Receiving this information in the public domain signals the Board’s commitment to creating an open culture and also helps to meet the duty of candour.

The Q2 Lessons Learned report provides details of the activity and key lessons arising from incidents, complaints, claims, Central Alerting System (CAS alerts) and Inquests.

The learning in Q2 is reflective of previous periods, although learning from incidents has rarely been found to be a causal or contributory factor to incidents. The shortcomings in care planning are an ongoing issue; the Nurse Executive has recently considered this issue and will be looking for an alternative way of communicating care consistently due to the longstanding nature of the issue.

There is a need for a formal improvement plan to ensure there is accurate reporting of all incidents. The recent (September 2017) National Report and Learning System report identifies the Trust in the lower quartile of reporting.

A recent audit of Duty of Candour compliance - of a sample of 80 incidents and 80 complaints between April 2016 and March 2017 - suggests that although in the event of a serious incident the Trust consistently meets this requirement, it is necessary to improve our delivery of this duty in moderate to severe impact incidents and all complaints. The audit is being repeated and presented to the Quality Committee in July 2018.

The Deputy Director of Nursing is comparing reports from other ‘good’ and ‘outstanding’ rated Trusts to explore how better to present the information in order to assure the Board that the Trust identifies, reports and learns from incidents of all kinds.
1.0 Introduction

The Board of Directors receives a quarterly update on adverse incidents, which includes summary information about some of the themes of learning and also performance data. Receiving this information in the public domain signals the Board’s commitment to creating an open culture and also helps to meet the duty of candour.

The Q2 Lessons Learned report provides details of the activity and key lessons arising from incidents, complaints, claims, Central Alerting System (CAS alerts) and Inquests.

2.0 Lessons Learned

2.1 Duty of Candour Audit

Since 2014 there has been a statutory requirement for the Trust to meet Duty of Candour under CQC regulation 20:

'Health and Social Care Act 2008 (Regulated Activities) Regulations 2014: Regulation 20
The intention of this regulation is to ensure that providers are open and transparent with people who use services and other 'relevant persons' (people acting lawfully on their behalf) in general in relation to care and treatment. It also sets out some specific requirements that providers must follow when things go wrong with care and treatment, including informing people about the incident, providing reasonable support, providing truthful information and an apology when things go wrong.'[1]

The Trust's Being Open and Duty of Candour policy outlines the steps that should be taken by all staff involved in any incident suspected of, or resulting in, moderate harm or above. An audit was undertaken using a sample of 80 incidents and 80 complaints received between April 2016 and March 2017 were reviewed to identify the Trust's compliance with this policy and the CQC regulation. Being Open is at the heart of the complaints process, with Duty of Candour applying in the majority to serious incidents.

What is required of the Trust and our staff?

- Ensure a responsive culture of honesty, policies and procedures to support candour
- Notify the relevant person as soon as reasonably practicable that a serious incident has occurred.
- Provide a clear account of the incident with the next steps e.g. investigation
- Apologise, where possible in person.
- Offer appropriate support e.g. access to counselling
- Write to the person, with details of the above steps
- Stay in touch – keep the person updated and provide a written outcome of any further enquiries
- Keep records of all contact e.g. ePJS, Datix

Findings of the audit

The audit methodology used was a review of Datix records, ePJS notes, serious incident investigations and complaint letters. It found evidence of reliable disclosures to those affected by serious incidents with a significant improvement in face-to-face apologies. However, written contact following disclosure was limited by not explicitly providing an apology for the incident and focussing on support, sympathy or condolence.

The recording of Duty of Candour on Datix was not being completed consistently throughout the investigation process, which limited the information that could be used in the audit. If completed, the Clinical Academic Groups (CAGs) would have the opportunity to demonstrate where Duty of Candour is met.

Although serious incident investigation reports were found to display openness and clear accounts of the incidents that occurred, providing those affected with a step-by-step account of the incident being investigated, reports did not always clearly outline the steps taken by clinicians or senior management through to the conclusion of the investigation. Questions received from those affected were not consistently added into the terms of reference of the investigation.

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For complaints, on the whole, Being Open is evidenced within responses. Aspects that are improving are offers of meetings with service users and families. These are recognised as being a constructive way of attempting to resolve complaints.

**Learning**
The Trust is not consistently meeting its Duty of Candour.

An improvement plan is in place. The audit was presented to the Quality Committee November 2017; the committee will take a report on 2017 – 18 data when available.

**2.2 External Review of serious incidents within the Trust**
A high-quality investigation process leads to learning which addresses root causes of incidents and improves the care the Trust provides to patients. During Q2, the Trust commissioned an external review of a sample of 50 serious incident investigations by an independent human factors consultant. The purpose of this was to evaluate our internal investigations, identifying good practice and areas for improvement.

The reviewer identified several areas of good practice in the investigation reports reviewed. These included the Trust’s openness and commitment to learning and improvement, demonstrating a balance between what is done well and areas of concern, humanity to those involved and the use of an analysis process for the areas of concern.

**Learning included:**
- The need to look beyond non-compliance i.e. what was the reason for the team not complying with a protocol or procedure.
- The need to ensure analysis is fully captured within the investigation report and incorporates all contributory factors.
- The need to strengthening recommendations and action plans by moving from moderately strong to strong recommendations, which is a move away from recommendations that focus on re-writing policy or protocol.
- The need to further improve organisational learning by sharing practice/incident investigations

**What steps have we taken?**
- We have incorporated key case studies into the Practical Guide to Structured Investigations Training to demonstrate analysis of varying standards.
- Commenced the Trust Serious Incident Review Group in November 2017. The group will review serious incident investigation reports to ensure:
  - High quality reports with appropriate analysis
  - Duty of Candour is met
  - Recommendations and actions are strong, address root causes and that learning is shared across the Trust.

The same consultant is now being commissioned to review how the Trust addresses trends and themes of learning to ensure the focus is on bringing about improvement.

**2.3 Safety Connections – Kings Health Partners**
On 10 October 2017, the Trust took part in the Kings Health Partners (KHP) Safety Connections Network evening event, with a SLaM presentation from the Clinical Director of the Mental Health Older Adults and Dementia CAG. The event focussed on the implementation of the mortality review process and learning that has been identified from this. The event was well attended by staff across KHP. The presentation provided an insight into the challenges and benefits of implementing mortality reviews in clinical practice.

SLaM is the host of the next Safety Connections Event which will be from 5pm on 23 January 2018 at the ORTUS Learning Centre. Speakers from across KHP will be speaking on Freedom to Speak Up – what have we learned so far. To book a place, please email gips@gstt.nhs.uk. Updates will be sent out nearer the time through the Trust intranet and via Yammer.
2.4 Mortality Review
The Trust is now reporting the learning from mortality reviews to the Trust Board on a quarterly basis. The data in this quarter indicated 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 and the remaining 4 were notified 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 included:
The need to improve risk management and sharing of the risks identified, improve the effectiveness of communication with Primary Care both regarding physical health needs and care planning implementation.

2.5 Blue Light Bulletins
Two Blue light bulletins were published in quarter 2. The first acted as a reminder to community teams on the standards for emergency equipment stock and ordering procedures. Equipment required includes
- Disposable CPR Pocket Mask
- Utility scissors (to cut clothing)
- Razor (to shave hair on chest prior to applying AED pads)
- Automated external defibrillator (AED)

The second bulletin resulted from an incident involving a ligature anchor point at the Bethlem Royal Hospital, a fire / smoke detector. The immediate review by the clinical team, Health and Safety lead and the Estates and Facilities department identified that these may be weight bearing and provide a ligature anchor point. Each inpatient service was asked to complete an audit overseen by the CAG Health and Safety Advisors identifying if these are present and to provide assurance of a local risk management plan.

2.6 Learning from Incidents concluding in Q2
There were 27 serious incident investigations submitted to commissioners in Q2, 11 of these were categorised under probable suicide. The investigations made recommendations leading to 113 actions which were recorded onto Datix.

<table>
<thead>
<tr>
<th>CAG</th>
<th>Number of reports submitted</th>
<th>Number of actions</th>
</tr>
</thead>
<tbody>
<tr>
<td>Acute Care</td>
<td>7</td>
<td>33</td>
</tr>
<tr>
<td>Addictions</td>
<td>2</td>
<td>6</td>
</tr>
<tr>
<td>Behavioural &amp; Developmental Psychiatry</td>
<td>5</td>
<td>25</td>
</tr>
<tr>
<td>Child and Adolescent Mental Health Services</td>
<td>1</td>
<td>12</td>
</tr>
<tr>
<td>MHOA and Dementia</td>
<td>3</td>
<td>14</td>
</tr>
<tr>
<td>Psychological Medicine &amp; Integrated Care</td>
<td>5</td>
<td>17</td>
</tr>
</tbody>
</table>
Psychosis

<table>
<thead>
<tr>
<th></th>
<th>4</th>
<th>6</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total</td>
<td>27</td>
<td>113</td>
</tr>
</tbody>
</table>

Each action is themed using the Datix action module, as part of the wider Learning Lessons audit being undertaken in Q3. A review of the themes within the module will be undertaken with an aim of further refining these.

Learning included:

- Trust’s Section 17 leave policy to be updated to include specific guidance on how patients can access local services if using longer periods of s17 leave outside of Trust services
- Trust Clinical Risk Assessment and Management of Harm Policy should be amended to incorporate guidance on risk events which occur when a patient is on s17
- Creation of standardised Nurse in Charge competency and delegation of duties
- Staff to be provided with information about medication bought over the internet
- The need to understand and communicate trends of Deliberate Self-Harm and disseminate the learning from this
- Improve staff awareness of Multi Agency Risk Assessment Conference (MARAC) and the role of the Trust representatives in the MARAC process

2.7 What are the similarities between the learning in incidents and from complaints investigations?

Serious Incident investigations look at the care and treatment the Trust provides prior to a serious incident occurring, whilst complaints can be raised at any point in care by a service user or appropriate person.

This section has looked at the topics of complaints first received in Q2 and how they relate to the recommendations from serious incident reports.

Although the topics of the complaints received under the category of ‘care and treatment’ are not in every incident, the top two topic sub-categories are identified in many of the lessons from serious incidents.

Table 2 Care and Treatment sub categories complaints

<table>
<thead>
<tr>
<th>Care and Treatment</th>
<th>51</th>
</tr>
</thead>
<tbody>
<tr>
<td>Concerns of patient's observations</td>
<td>1</td>
</tr>
<tr>
<td>Co-ordination of treatment</td>
<td>8</td>
</tr>
<tr>
<td>Error with prescription</td>
<td>1</td>
</tr>
<tr>
<td>Lack of continuity</td>
<td>4</td>
</tr>
<tr>
<td>Lack of pain management</td>
<td>1</td>
</tr>
<tr>
<td>Lack of therapies</td>
<td>4</td>
</tr>
<tr>
<td>Other</td>
<td>9</td>
</tr>
<tr>
<td>Patient being restrained or restricted</td>
<td>1</td>
</tr>
<tr>
<td>Poor Care Planning</td>
<td>11</td>
</tr>
<tr>
<td>Poor nursing care</td>
<td>2</td>
</tr>
<tr>
<td>Problems with medication</td>
<td>4</td>
</tr>
<tr>
<td>Waiting to see doctor/nurse once admitted</td>
<td>1</td>
</tr>
<tr>
<td>Wrong diagnosis</td>
<td>1</td>
</tr>
<tr>
<td>Wrong medicine given</td>
<td>2</td>
</tr>
<tr>
<td>Wrong treatment given</td>
<td>1</td>
</tr>
</tbody>
</table>

The highest number of complaints received are categorised under the sub-category of poor care planning, followed by issues with co-ordination of treatment. Lessons from incidents include:

- A failure or weakness in care planning and risk assessment
- A failure or weakness in coordination of treatment
- Improvement of response needed when a patient DNAs / misses appointments
- Recording the outcome of zoning protocols and using zoning to consider patients who are not engaging needs to improve to be consistent in all teams
- Self-Harm risks should be assessed and closely managed in all clinical environments.

3 Reported data in Q2

3.1 NRLS Data

In September 2017, the National Reporting and Learning System (NRLS) released the biannual report out on patient safety incidents for the reporting period October 2016 – March 2017.

SLaM reported a total of 2,633 incidents to NRLS, 19.69 per 1000 bed days, lower than the national median of 44.33 per 1000 bed days. The Trust appears in the lower quartile of the reporting range, work is ongoing to promote an accurate incident reporting culture.

3.2 Incident data

Reported incidents inform Trust strategy, highlight areas of risk and are used to improve patient safety. During Q2, 2,813 incidents were reported on the Datix system. As indicated in the run chart below, the numbers fluctuate somewhat between the upper and lower limits but remain relatively static within the 800 to 1200 range.

![Reported incidents 2013/14 - 2017/18 Q2](https://report.nrls.nhs.uk/explorerTool/default.aspx)

Figure 1 Reported incident 2013 - 2017

Incidents are categorised by the reporter and validated by the authoriser. Data on incident type is reviewed at CAG level and selected data on relevant types of incident reported to specific committees e.g. Safe and Therapeutic Services Committee review Violence/Aggression/Assault data/ prone restraint. In Q2, the types of incidents reported most frequently across the range of severities were 1. Violence/Aggression/Assault (977); 2. Self-Harm (342) and 3. Clinical Care which includes practice relating to the management of patients with substance misuse and pressure ulcers (300).

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3 [https://report.nrls.nhs.uk/explorerTool/default.aspx](https://report.nrls.nhs.uk/explorerTool/default.aspx)
### Table 3 Types of incident reported in Q2

<table>
<thead>
<tr>
<th>Type of incident</th>
<th>A - Death</th>
<th>B - Severe</th>
<th>C - Moderate</th>
<th>D - Low</th>
<th>E - No Adverse Outcome</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>AWOL/Abscond/Failed To Return</td>
<td>0</td>
<td>2</td>
<td>56</td>
<td>145</td>
<td>56</td>
<td>259</td>
</tr>
<tr>
<td>Clinical Care (Inc. Substance Misuse/Pressure Ulcer/Wound)</td>
<td>0</td>
<td>2</td>
<td>89</td>
<td>131</td>
<td>78</td>
<td>300</td>
</tr>
<tr>
<td>Confidentiality/IT/Health Records</td>
<td>0</td>
<td>2</td>
<td>20</td>
<td>40</td>
<td>45</td>
<td>107</td>
</tr>
<tr>
<td>Death</td>
<td>100</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>100</td>
</tr>
<tr>
<td>Medication</td>
<td>0</td>
<td>1</td>
<td>89</td>
<td>37</td>
<td>29</td>
<td>156</td>
</tr>
<tr>
<td>MHA Breach</td>
<td>0</td>
<td>0</td>
<td>6</td>
<td>10</td>
<td>9</td>
<td>25</td>
</tr>
<tr>
<td>Patient Accidents/Health &amp; Safety/Fire</td>
<td>0</td>
<td>3</td>
<td>31</td>
<td>129</td>
<td>68</td>
<td>231</td>
</tr>
<tr>
<td>Security</td>
<td>0</td>
<td>2</td>
<td>31</td>
<td>60</td>
<td>62</td>
<td>155</td>
</tr>
<tr>
<td>Self-Harm</td>
<td>0</td>
<td>5</td>
<td>101</td>
<td>183</td>
<td>53</td>
<td>342</td>
</tr>
<tr>
<td>Staff Accidents/Health &amp; Safety/Fire</td>
<td>0</td>
<td>0</td>
<td>13</td>
<td>35</td>
<td>18</td>
<td>66</td>
</tr>
<tr>
<td>Staff Issues</td>
<td>0</td>
<td>1</td>
<td>18</td>
<td>46</td>
<td>30</td>
<td>95</td>
</tr>
<tr>
<td>Violence/Aggression/Assault</td>
<td>1</td>
<td>8</td>
<td>205</td>
<td>490</td>
<td>273</td>
<td>977</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>101</strong></td>
<td><strong>26</strong></td>
<td><strong>659</strong></td>
<td><strong>1306</strong></td>
<td><strong>721</strong></td>
<td><strong>2813</strong></td>
</tr>
</tbody>
</table>

#### Clinical Care (Inc. Substance Misuse/Pressure Ulcer/Wound)

The majority in this category were recorded under Patient Admission and are monitored via Acute CAG governance processes. Key areas for learning from this data are the interrelated issues of bed availability and delayed admissions.

### Table 4 Category (Clinical Care)

<table>
<thead>
<tr>
<th>Category of incident (Clinical Care)</th>
<th>Number</th>
</tr>
</thead>
<tbody>
<tr>
<td>Food Issues</td>
<td>2</td>
</tr>
<tr>
<td>Inappropriate Behaviour (Not Violent)</td>
<td>36</td>
</tr>
<tr>
<td>Neglect</td>
<td>16</td>
</tr>
<tr>
<td>Pathology Test Results/Reports/Samples</td>
<td>6</td>
</tr>
<tr>
<td>Patient Admission</td>
<td>129</td>
</tr>
<tr>
<td>Patient Discharge</td>
<td>7</td>
</tr>
<tr>
<td>Patient Financial Loss</td>
<td>5</td>
</tr>
<tr>
<td>Patient Monitoring (Including Pressure Ulcer/Wound)</td>
<td>25</td>
</tr>
<tr>
<td>Patient Unwell/Illness</td>
<td>47</td>
</tr>
<tr>
<td>Substance Misuse - Possession/Supply Of</td>
<td>27</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>300</strong></td>
</tr>
</tbody>
</table>

The Clinical Directors are writing an escalation process to ensure that when there are difficulties with:

A) The provision of a timely MHA Assessment

OR

B) when there is a delay in a patient being able to access an appropriate inpatient bed an accurate Datix report is completed in order that issues can be dealt with and escalated where necessary to ensure any risks to safe care can be understood.
Self-Harm

The majority of these incidents reported low or no harm. CAMHS reported the highest number of self-harm incidents in Q2 (216), most of which occurred in an inpatient setting (185). In response to this, CAMHS CAG has recently commissioned a quality improvement project to reduce the numbers of self-harm incidents in their inpatient services with oversight from the CAG serious incident panel.

Table 5 Category of incident (Self-harm)

<table>
<thead>
<tr>
<th>Category of incident (Self-harm)</th>
<th>B - Severe</th>
<th>C - Moderate</th>
<th>D - Low</th>
<th>E - No Adverse Outcome</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Accidental Self Harm</td>
<td>0</td>
<td>1</td>
<td>3</td>
<td>0</td>
<td>4</td>
</tr>
<tr>
<td>Actual Self-Harm</td>
<td>1</td>
<td>55</td>
<td>112</td>
<td>24</td>
<td>192</td>
</tr>
<tr>
<td>Alleged/Suspected Self-Harm</td>
<td>0</td>
<td>1</td>
<td>13</td>
<td>5</td>
<td>19</td>
</tr>
<tr>
<td>Attempted Self-Harm</td>
<td>0</td>
<td>5</td>
<td>28</td>
<td>15</td>
<td>48</td>
</tr>
<tr>
<td>Attempted Suicide</td>
<td>4</td>
<td>36</td>
<td>22</td>
<td>5</td>
<td>67</td>
</tr>
<tr>
<td>Threatened Self-Harm</td>
<td>0</td>
<td>3</td>
<td>5</td>
<td>4</td>
<td>12</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>5</strong></td>
<td><strong>101</strong></td>
<td><strong>183</strong></td>
<td><strong>53</strong></td>
<td><strong>342</strong></td>
</tr>
</tbody>
</table>

Violence/Aggression/Assault

This is the highest reported category of incident within the Trust for Q2 at 977; of these, 762 occurred in inpatient settings with the three highest reports: Acute CAG (429) followed by BDP (99) and CAMHS (99).

A further breakdown is shown in the table below.

Table 6 Category of Incident (Violence/Aggression/Assault)

<table>
<thead>
<tr>
<th>Category of Incident (Violence/Aggression/Assault)</th>
<th>Number</th>
</tr>
</thead>
<tbody>
<tr>
<td>Assault</td>
<td>490</td>
</tr>
<tr>
<td>Challenging Behaviour</td>
<td>407</td>
</tr>
<tr>
<td>Harassment</td>
<td>53</td>
</tr>
<tr>
<td>Homicide (Murder) BY Patient</td>
<td>2</td>
</tr>
<tr>
<td>Sexual Assault</td>
<td>25</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>977</strong></td>
</tr>
</tbody>
</table>

Serious Incidents by Reported Borough

The figure below shows the spread of serious incidents across the boroughs where SLaM commissions services. As expected, the boroughs with more services have an increased number of incident reports.
3.3 Notified Serious Incident

23 serious incidents were reported to commissioners in Q2, one being de-escalated on receipt of further information. Figure 3 highlights the Serious Incidents notified by CAG, Figure 4 shows LSLC commissioner reported to and Table 8 CCGs outside that area.

![Figure 3 LSLC Serious Incidents by Severity and Borough](image)

![Figure 4 Serious Incident requiring investigation Q2 2017/18](image)

3.4 Investigations

Of the 22 incidents reported as serious incidents, one is undergoing an independent investigation; four are being investigated with board level oversight and 17 will are being overseen at CAG level.

<table>
<thead>
<tr>
<th>Type of investigation / Category / CCG</th>
<th>Croydon CCG</th>
<th>Lambeth CCG</th>
<th>Lewisham CCG</th>
<th>Southwark CCG</th>
<th>NHS England</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Comprehensive (Level 2)</td>
<td>2</td>
<td>1</td>
<td>1</td>
<td>0</td>
<td>0</td>
<td>4</td>
</tr>
<tr>
<td>Alleged homicide by patient</td>
<td>0</td>
<td>1</td>
<td>1</td>
<td>0</td>
<td>0</td>
<td>2</td>
</tr>
<tr>
<td>Probable Suicide</td>
<td>1</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>1</td>
</tr>
<tr>
<td>Sexual Assault By PATIENT</td>
<td>1</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>1</td>
</tr>
<tr>
<td>Concise (Level 1)</td>
<td>3</td>
<td>4</td>
<td>6</td>
<td>4</td>
<td>17</td>
<td></td>
</tr>
<tr>
<td>Abscond - Informal Patient</td>
<td>0</td>
<td>0</td>
<td>1</td>
<td>0</td>
<td>0</td>
<td>1</td>
</tr>
</tbody>
</table>
### Table 8 Current stage of Comprehensive investigations

<table>
<thead>
<tr>
<th>Investigations underway in Q2</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Acute Care – Attempted Suicide on an inpatient ward</strong></td>
</tr>
<tr>
<td>Investigation concluded, sign off meeting delayed.</td>
</tr>
<tr>
<td><strong>Acute Care – Probable Suicide on an inpatient ward</strong></td>
</tr>
<tr>
<td>Investigation underway following family engagement. Sign off being arranged for Q3</td>
</tr>
<tr>
<td><strong>Psychological Medicine &amp; Integrated Care</strong></td>
</tr>
<tr>
<td>Natural Causes</td>
</tr>
<tr>
<td>Investigation underway following family engagement. Sign off being arranged for Q3</td>
</tr>
<tr>
<td><strong>Acute CAG – Alleged fracture sustained following restraint</strong></td>
</tr>
<tr>
<td>Investigation underway, no contact received from patient or family.</td>
</tr>
<tr>
<td><strong>Psychological Medicine &amp; Integrated Care</strong></td>
</tr>
<tr>
<td>– Suspected physical assault on child by patient</td>
</tr>
<tr>
<td>Investigation underway, local Safeguarding Children Board aware of incident.</td>
</tr>
<tr>
<td><strong>Child and Adolescent Mental Health Services</strong></td>
</tr>
<tr>
<td>– Suspected physical assault on child by another child</td>
</tr>
<tr>
<td>Investigation underway, local Safeguarding Children Board aware of incident.</td>
</tr>
<tr>
<td><strong>Acute Care – Probable Suicide of a patient on leave from inpatient care</strong></td>
</tr>
<tr>
<td>Investigation underway, initial meeting held with family.</td>
</tr>
</tbody>
</table>

**Investigations commissioned in Q2**

| **Psychosis – Alleged homicide by community patient**                                      |
| Strategy meeting held, team independent of the Trust allocated to investigation, police family liaison leading on contact with family; interviews completed in SWL&STG and SLaM, investigation will include DHR. |
| **Acute Care – Probable Suicide of a patient who left inpatient ward**                     |
| Strategy meeting held, team independent of the CAG team allocated to investigation.         |
| **Behavioural & Developmental Psychiatry – Alleged sexual assault by patient**             |
| Strategy meeting held, patient not yet charged investigation currently suspended.           |

#### Learning from Comprehensive Investigations completed Q2

**Probable Suicide of a patient on leave [Acute]**

No causal factors identified. Learning identified from investigation includes

- Process for review of section 17 leave when patient is on longer periods of leave
- Standardisation of practice in ward rounds
- Adequate handover of information when staff are on leave

**Self-harm of an inpatient [Behavioural & Developmental Psychiatry]**

No causal factors identified. Learning identified from investigation includes

- The need for a thematic review of incidents of Deliberate Self Harm episodes across the Trust
- Review of complex patients on ward

**Probable Suicide on an inpatient ward [MHOA and Dementia]**

Learning identified in investigation includes

- Standardisation of nurse in charge competency
- Using an effective handover process
3.5 Central Alerting System (CAS) Data
The Trust received 27 alerts from the Central Alerting System, of these 3 were patient safety alerts, where actions were identified these were completed. The 2 alerts that required actions:

- Risk of death and severe harm from ingestion of superabsorbent polymer gel granules. The alert was shared across the Trust and assurance given on actions taken.
- Severe harm and death from infusing total parenteral nutrition too rapidly in babies. Although the Trust is unlikely to have a role within this alert it was shared with the perinatal services to raise awareness.

3.6 Inquest Data
No Preventing Future Deaths were received during the quarter.

During Q2 19 inquests took place. One verdict has not been received as the Trust was not deemed an interested party at the time – the verdict has been requested.

Table 9 Inquests occurring in Q2

<table>
<thead>
<tr>
<th>Conclusion</th>
<th>CAG</th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Addictions</td>
<td>BDP</td>
<td>MHOAD</td>
<td>PMIC</td>
<td>Psychosis</td>
<td>Total</td>
</tr>
<tr>
<td>Accidental</td>
<td>1</td>
<td>0</td>
<td>0</td>
<td>2</td>
<td>0</td>
<td>3</td>
</tr>
<tr>
<td>Narrative</td>
<td>0</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>4</td>
</tr>
<tr>
<td>Open</td>
<td>0</td>
<td>0</td>
<td>1</td>
<td>1</td>
<td>2</td>
<td>4</td>
</tr>
<tr>
<td>Suicide</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>2</td>
<td>2</td>
<td>7</td>
</tr>
<tr>
<td>Awaited</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>1</td>
<td>0</td>
<td>1</td>
</tr>
<tr>
<td>Total</td>
<td>1</td>
<td>2</td>
<td>4</td>
<td>7</td>
<td>5</td>
<td>19</td>
</tr>
</tbody>
</table>

3.7 Claims Data
Table 10 Claims received in Q2

<table>
<thead>
<tr>
<th>CAG</th>
<th>Type</th>
<th>Number received</th>
</tr>
</thead>
<tbody>
<tr>
<td>Acute Care</td>
<td>Public liability</td>
<td>1</td>
</tr>
<tr>
<td>Corporate</td>
<td>Public liability</td>
<td>2</td>
</tr>
<tr>
<td>Psychological Medicine &amp; Integrated Care</td>
<td>Public liability</td>
<td>1</td>
</tr>
</tbody>
</table>

Of note this quarter, four public liability claims were received; it is unusual to receive this number at once. Two of the claims relate to slips/trips with the others relating to an injury and an assault. Of these claims, two were from incidents in 2017 and the remaining two in 2015.

3.8 Complaints data
125 complaints were first received in the quarter, 10 complaints were reopened following an initial response being received.
The two highest topics of complaint were issues with Care and Treatment (51) and Attitude/Behaviour of staff (28). When looking at these in more detail, they link to similar themes and learning areas identified within serious incident investigations. ‘Poor Care Planning’ and Co-ordination of Treatment are commonly identified as factors within the SI process which is included earlier in the report.

Table 12 Top primary subjects by sub-category

<table>
<thead>
<tr>
<th>Sub-subject of complaint</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Attitude/Behaviour</td>
<td>28</td>
</tr>
<tr>
<td>Alleged assault</td>
<td>4</td>
</tr>
<tr>
<td>Behaviour</td>
<td>16</td>
</tr>
<tr>
<td>Inappropriate comments</td>
<td>3</td>
</tr>
<tr>
<td>Insensitive to patient needs</td>
<td>3</td>
</tr>
<tr>
<td>Other</td>
<td>1</td>
</tr>
</tbody>
</table>
A breakdown of Care and Treatment by sub-subject can be seen above at Table 3 above.

4 **Key Recommendations from the report**
1. Report to be made available to all services via CAG governance meetings and through the intranet.
2. Learning to be triangulated with quality improvement initiatives to identify gaps in learning.
3. Share the requirements of Duty of Candour with clinicians, encourage open dialogue and discussion about the requirements.
4. Formal improvement plan to be developed to ensure accurate reporting of patient safety incidents.

The Board of Directors is asked to:
- Note the content of the report.
- Note the ongoing work by the Deputy Director of Nursing to improve the report in order to better assure the Board that learning from incidents of all kinds is being extracted and is driving improvement.

**Lucy Stubbings, Head of Patient Safety**
**Title** |
**BUSINESS DEVELOPMENT INVESTMENT COMMITTEE UPDATE**

| Non-Executive Director | JUNE MULROY |

### 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>Actions proposed to address key issues</th>
</tr>
</thead>
<tbody>
<tr>
<td>Due diligence on a commercial opportunity was discussed</td>
</tr>
<tr>
<td>South East London STP Provider Federation MOU</td>
</tr>
</tbody>
</table>

### Key points of assurance

**Due diligence:** Board Meeting after 15 Jan will have an overview of the documents to be signed in relation to the commercial opportunity.

### Key risks to flag

N/A
COMMITTEE REPORT TO THE TRUST BOARD: PUBLIC
19 DECEMBER 2017

Non-Executive Director | JUNE MULROY

Purpose of the paper

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

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

Note. Available upon request are the draft minutes upon which this key issues summary is based

(A). KEY ISSUES SUMMARY (section C below flags key risks for Board attention)

A1. 2017/18 Performance report (Committee agenda item 6)

The majority of the FPC meeting was used to discuss in detail the risks identified in the paper. The FPC noted that the report continued to develop and improve in form and content.

The FPC discussed methods of managing and balancing admissions (normally 8 per week on average) and discharges, in particular over the Christmas and New Year period (where admissions might rise to 30 per week) for which KD noted some potential concerns. KD advised that further to JM’s queries, management methods discussed included: agreement to wait (typically in A&E) for admission; more frequent reviews to identify service users who can be discharged appropriately; increased use of Home Treatment; and street triage. KD noted that Home Treatment is now available 24 hours, rather than 12 hours (8am to 8pm) as previously.

KD noted that SLaM is working with A&E departments to avoid lengthy waits, especially waits over 12 hours which are particularly serious.

Regarding early interventions (which, further to JM’s query KD advised was sustainable) KD noted the availability of Winter funding which would help support this.

RP, JM and MP noted the importance of ensuring a coordinated approach across the local health economy, in particular maintaining appropriate relationships with Acute Trusts and commissioners.

The Governor Observer (JD) noted a concern raised by the Board of Governors that reductions in length of stay should not cause an increase in readmissions. The FPC noted that where appropriate discharge would be to another service which would support the service user as appropriate.

Key actions agreed were:
- The FPC will discuss the Risk Management Strategy and Assurance Framework at its next meeting
- The FPC suggests the Board of Directors and the Council of Governors receive a ‘mini presentation’ about SLaM’s systems for managing and balancing admissions and discharges
SLaM needs to develop an appropriate narrative about usage of private beds and the systems approach to this

A2. CIPs and QIPPs (Committee agenda item 7)

CIPs
GH advised that 2017/18 CIPs delivery was broadly on track. JM queried whether input from senior management was sustainable in maintaining CIPs performance. KD and GH noted improvements in the ability to delegate matters throughout their teams and agreed further improvements were needed. GH and MP noted that CIP schemes were increasingly ‘transformational’ in nature, especially in view of the 5 to 10 year contracting systems ultimately envisaged by NHS. Responding to RPs’s query on the quality dashboard, KD advised that she and BM were leading on this and would make a presentation to the January 2018 Board.

QIPPs
For 2017/18, GH advised that SLaM is in discussion with NHS England regarding £1.1m which SLaM considers NHS England should repay given the absence of a related scheme. For 2018/19, further to JM’s query the meeting discussed the position with Croydon and issues around Croydon’s view that it should not pay for ‘empty’ beds intended to allow for unplanned fluctuations in bed usage. MP noted that SLaM needs to put Croydon on notice that this would be a unilateral move by Croydon, contrary to SLaM’s advice, would be at Croydon’s risk and would mean Croydon cannot invest in the community. Further to JM’s query MP advised that Croydon is a deprived area, but not the most deprived area dealt with by SLaM. KD noted that SLaM had experienced similar difficulties with Croydon over the past 2 years

Key actions agreed were:
- SLaM needs to escalate the issue with Croydon
- The nature of the PMO’s function needs to move from assurance to transformation support

A3. Core financial risks: risk assessment (Committee agenda item 9)
This paper provided an update on the core financial risks to the operation of the financial environment of the Trust for the financial year 2017/18. GH and AB advised that SLaM is on track to achieve the challenging 2017/18 control total and that this requires significant reliance on non-recurring items (such as planned disposals of £4.5m, of which £3.9m has been realised to date). However, SLaM is seeking wherever possible to identify recurring savings. MP advised that NHS leadership’s focus is on building credibility through achieving the 2017/18 NHS control total.

The meeting discussed STF funding system, the rules for which were unchanged from 2016/17, albeit that the quantum of funds available for the ‘residual bonus’ is not yet known. AB advised that, strictly, there was no distinction

Key actions agreed were:
- GH agreed that a version of this paper, updated to quarter 3, would be presented to the January 2018 Board for discussion. MP suggested that the paper should include scenario analysis to identify the ‘best’ option for SLaM as regards achieving 2017/18 and 2017/19 control totals

(B). Key points of assurance
- KD confirmed that SLaM can sustain early intervention performance
- GH confirmed that 2017/18 CIP delivery is challenging but achievable

(C). Key risks to flag to Board (key issues summary section A above gives more background)
- KD noted some potential concerns in managing and balancing admissions and discharges over the Christmas and New Year period
- The contracting position with Croydon needs to be escalated

(D). Issues to be brought to the attention of other Committees
- The Audit Committee will receive a copy of this key issues report as a matter of course.
COMMITTEE REPORT TO THE TRUST BOARD: PUBLIC
19 DECEMBER 2017

Title | QUALITY COMMITTEE UPDATE
--- | ---
Non-Executive Director | Anna Walker

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.

<table>
<thead>
<tr>
<th>KEY ISSUES SUMMARY</th>
<th>Actions proposed to address key issues</th>
</tr>
</thead>
<tbody>
<tr>
<td>Duty of candour annual assessment</td>
<td>Focussed action plan to be considered when 2017 data is available. Latest audit highlights show a need for improvement.</td>
</tr>
<tr>
<td>Quality priorities: requirement to set and clarify</td>
<td>Special meeting of Quality Committee to be held in April 2018 to consider quality priorities for 2018/9 before they go to the Audit Committee.</td>
</tr>
<tr>
<td>Community Services CQC action plan</td>
<td>Monthly oversight on progress at compliance meetings and periodic reports to QC.</td>
</tr>
<tr>
<td>PMIC challenges</td>
<td>Escalated to Board through this paper.</td>
</tr>
<tr>
<td>Mandatory training compliance</td>
<td>Ongoing oversight at PACMAN; improvement but overall targets still not being met.</td>
</tr>
<tr>
<td>CAMHS challenges</td>
<td>Escalated to Board for full discussion in January 2018.</td>
</tr>
<tr>
<td>Current A&amp;E pressures</td>
<td>Added to the Performance report at the December Board.</td>
</tr>
<tr>
<td>Quality Governance: clarification of Committee’s terms of reference and reporting lines</td>
<td>Updated draft proposals to be brought to the QC meeting in January.</td>
</tr>
</tbody>
</table>

Key points of assurance

**Duty of Candour annual assessment**
The Committee received the annual assessment of this statutory obligation. Despite improvements in some areas, the audit results were less good than 2014. The Committee agreed on the format for the resultant action plan, stripping out the data by CAG and ensuring that the actions are SMART (Specific, Measurable, Achievable, Realistic and Time-bound). When the 2017 data is available, the action plan will be brought back to the Committee with a refined set of actions and progress tracker.

**Quality Priorities**
The Committee agreed that it needed regular reports on all of the 2017/18 priorities. A special meeting of the Committee will be convened for April 2018 to consider the quality priorities for 2018/19 and performance on the 2017/18 priorities.

**CQC Community Services inspection action plan**
The Committee ratified the plan. Progress against it will be added to the Quality Compliance meeting agendas so that there is monthly oversight. The QC will also get regular reports on progress.

**Patient Involvement Outcomes Framework**
The PPI policy has gone to the Policy Working Party and is the subject of a Board Deep Dive on...
December. Board input will be sought before submission to the CQC in 2018. It was agreed that clear outcomes were needed from the activity so progress could be tracked.

Mandatory training compliance
Improvements in some CAGs have been reported. Physical Health Awareness training compliance had also been a cause for concern, but has moved from 0% compliance to 60% since the beginning of the year. A review of training was being carried out to ensure staff were not being asked to do non-essential activities.

Quality Committee terms of reference and quality governance
The Committee welcomed the three executive committees: Quality Matters, Quality Compliance and PACMAN. It was agreed that the QC now needed to clarify its role so it adds value. It has begun to create a robust framework designed to clarify its business drivers e.g. Quality Priorities, relationship to risk and the Board Assurance Framework and relations with CAGs. It was agreed that reporting lines and relationships with other committees should be set out more clearly to ensure a “floor to Board” approach.

Key risks to flag

PMIC
The Committee took a report from the PMIC CAG which set out barriers to improving quality. It was agreed that key risks arising would be escalated to the Board. The key risks identified are:

- **Disinvestment / QIPP**: this is particularly acute in (a) Croydon, where the waiting list recently reached over 1,000; (b) Lewisham, where IAPT funding has been withdrawn; and (c) Lambeth, where there are questions about the sustainability of the A&L model.
- **Estates**, where some property is not fit for purpose and future plans are not known, meaning that a new service model which should have gone live on 1 April still has not launched.
- **Lack of sustainable funding** e.g. Core24 investment is for one year only and is challenging to long-term planning, while IAPT success targets are due to increase 25% by 2021, but no funding has been provided by commissioners to achieve that.
- **Community Services** e.g. caseloads (Croydon); waiting lists (Lewisham); efforts to move patients on to the Care Programme Approach (CPA).
- **Specialist services** e.g. the risks to safety associated with 7-8 week waiting lists for perinatal services in Croydon.

CAMHS: commissioning issues and access to beds
The main issues are:

- Croydon CAMHS capped funding for Tier 4 outpatients reached its ceiling in May 2017 and there is a growing number of young people in Croydon who do not have access to services. Legal advice has been sought on challenging the cuts on the basis of an implied contract.
- Planned cuts to the Southwark CAMHS budgets which represent a 20-25% reduction on overall spend.

Mental Health in A&E
The Committee received a report highlighting the key risks involved in long waits for mental health beds in Emergency Departments, which are not designed for a mental health purpose and lack appropriately trained staff. It is recommended that this report is escalated for discussion at the Board.

- Most of the 4-hour breaches happen in Southwark.
- SLaM serves four EDs, but SLaM patients present at other EDs, so the pressure is not limited to those four within the area.
- From 11 December, the police may no longer detain suspects who are intoxicated, are children or who have suspected mental health problems in the cells. This will lead to an increase of s.136 detentions and demand for a designated place of safety.
- SLaM is working with KCH, particularly on developing a Clinical Decisions Unit (CDU) in A and E.

Issues to be brought to the attention of other committees

Quality Committee terms of reference and quality governance
The Committee is creating a robust framework designed to clarify its business drivers e.g. Quality Priorities, Board Assurance Framework and escalation. Reporting lines and relationships with other committees will also be set out more clearly.

Quality Priorities
A special meeting of the Committee will be convened for April 2018 to consider all of the quality priorities, including those where work is being undertaken in other areas e.g. under the Equalities and Workforce Committee.
Report to the Trust Board: Public
19 December 2017

Title: New Associate Hospital Managers
Author: Kay Burton, Assistant Director of Mental Health Legislation
Accountable Director: Beverley Murphy, Director of Nursing

Purpose of the paper
To provide the Board with information to enable them to approve the new Associate Hospital Managers (AHMs) to carry out the delegated functions of the Board under section 23 of the Mental Health Act 1983.

Executive summary
A joint recruitment for new AHMs was carried out with Oxleas NHS Trust. Nine AHMs were recruited, with seven opting to carry out the role at South London and Maudsley NHS Foundation Trust. The AHMs have been working through an induction and mentoring programme. Two have completed and are ready to begin the role.

Committees where this item has been considered
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<th>Date</th>
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<tr>
<td>7 December 2017</td>
<td>Trustwide Mental Health Law Committee</td>
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Background
The Mental Health Act 1983 Code of Practice (2015) at paragraph 38.3 states: “The hospital managers – meaning the organisation or individual in charge of the hospital – must either consider discharge themselves or arrange for their power to be exercised on their behalf by a ‘managers panel’.” To meet this requirement the Trust appoints office holders to carry out this role on their behalf. The Code further states: “In all cases, the board (or the equivalent) of the organisation concerned should ensure that the people appointed properly understand their role and the working of the Act ….” The AHMs within South London and Maudsley NHS Trust are recruited and trained to meet the required level of competency. The names of those meeting the standard are presented to the Board for approval to confirm they may act on the Board’s behalf.

In May 2017, a group of new AHMs were recruited jointly with Oxleas NHS Trust to carry out the delegated functions of the Board under section 23 of the Mental Health Act 1983. A total of nine have been recruited, with seven opting to carry out the role at South London and Maudsley NHS Foundation Trust.

Two have now completed their induction which included:
- Observation of three or more hearings.
- Two training sessions with the Heads of Mental Health Law for Oxleas and SLaM, and the SLaM MHA Training and Policy Advisor.
- Support from a mentor who is an experienced Associate Hospital Manager.
- DBS and Occupational Health clearance.
- Signed off by their mentors to have achieved a required level of competence to take on the role of Associate Hospital Manager.

The persons named below have successfully completed the induction process and are considered by their mentors to be competent to now undertake the AHM role.
- Pamela Russell
- Barry Allen

Board approval for these two new AHMs is required.
REPORT TO THE TRUST BOARD: PUBLIC

19 December 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

Lobbying

In September, the Governors wrote to the local Clinical Commissioning Groups to express their concerns regarding mental health funding. Replies have now been received from Ross Graves, Managing Director for Southwark CCG, and Moira McGrath, Director of Integrated Commissioning (Adults) for Lambeth CCG.

The next step in the Governors’ lobbying activity is to write to local MPs, and the Lead Governor will be asking the Council to support the text at the next Council of Governors meeting.

The Governors have also arranged a meeting with Helen Hayes MP (Dulwich and West Norwood).

Council of Governors meeting 14 December

At the time of writing, the December Council of Governors meeting has not yet taken place. However, as well as the usual working group reports and finance / performance updates, the agenda includes presentations from Jacqui Dyer and Patrick Vernon about Black Thrive, and Alan Downey will be talking about the Maudsley Charity.

The Council of Governors will also be taking the Nominations Committee’s recommendations for the appointment of a new Non-Executive Director.

New Governors’ induction training

An induction event for new Governors was held on 30 November. Introduced by Roger Paffard and Jenny Cobley, the session was designed as an introduction to SLaM and the
role of a Governor. Andy Bell, Director of Finance, also attended and talked through the finance reports that Governors receive at Council of Governors meetings, explaining what the data means and issues to be looking out for.

It was an energised afternoon, with plenty of insightful questions from the new Governors, who have a wide breadth of experience, expertise and interests. We are very much looking forward to working with them.

**Planning and Strategy Working Group**

The group met on 21 November 2017. The agenda included a presentation on performance from Kristin Dominy, Chief Operating Officer, and Harold Bennison, Director of Performance, Contracts and Operational Performance, who provided a summary of:

- roles and responsibilities;
- the impact of increasing financial restraint on outcomes;
- the opportunities and challenges of partnership working;
- the difficulties associated with implementing complex systems and processes; and
- the opportunities presented by the Quality Improvement programme to support whole systems change.

The group felt that the presentation increased their understanding of the importance, complexity and level of responsibility of the role of the team, the need to work in collaborative partnership within and across the Trust, aiming to achieve service improvements against a background of financial and resource restrictions and challenging the broader health system to deliver parity of equality for mental health. The group would welcome a further presentation with a focus on performance achievement against plan.

Altaf Kara, Director of Strategy and Commercial, also attended and updated Governors on the progress of Trust strategies. There was recognition of the need to deliver many and complex projects against tight schedules and resource restraints, but the group expressed concern about the potential impact of such challenging work on business as usual. Governors have requested a further session on progress of strategy development and implementation.

Janet Davies was appointed Deputy Chair, following the departure of Dr Francis Keaney, who has served the maximum number of terms.
Purpose of the paper

The terms of reference for the new Board Committee on Equalities and Workforce are presented here for formal ratification by the Board.

Executive summary

The terms of reference for the new Board Committee on Equalities and Workforce are attached.

They set out the role of the committee, which is to provide assurance to the Board on the recruitment, retention, management and development of the Trust’s workforce, and the development of an equalities strategy addressing both workforce and service provision.

The Committee has been established initially on a time limited basis and will be reviewed after six months.

Committees where this item has been considered

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<tr>
<th>Date</th>
<th>Committee/Meeting</th>
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<td>Equalities &amp; Workforce Committee</td>
</tr>
<tr>
<td>Via email 1</td>
<td>Senior Management Team</td>
</tr>
<tr>
<td>December 2017</td>
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Equalities and Workforce Committee 
of the Trust Board of Directors

Terms of Reference

Overall Purpose: The Board has established the Equalities and Workforce Committee, initially on a time-limited basis, to provide assurance to the Board on the recruitment, retention, management and development of the Trust’s workforce and the development of an equalities strategy addressing both workforce and service provision.

Key objectives:

- Evaluating and providing assurance to the Board on the implementation of the overall workforce strategy, including retention, recruitment, wellbeing, employee relations, freedom to speak up, education, training and leadership.

- Providing assurance to the Board on the development and implementation of a comprehensive Equalities Strategy for the trust addressing both workforce and service provision.

- Providing assurance to the Board on the progress of initiatives and activities to build staff engagement and increase the extent to which staff feel valued and proud of their work.

- Ensuring that the organisation has accurate workforce data and agreeing key performance indicators to ensure that progress against outcomes can be tracked and to support prioritisation.

Chair: Roger Paffard, Chair

Members: Anna Walker, Non-Executive Director
Mike Franklin, Non-Executive Director
Matthew Patrick, Chief Executive

Standing attendees:
Sally Storey, HR Director
Beverley Murphy, Director of Nursing
Rachel Evans, Director of Corporate Affairs
Arleen Elson, Chair of the BME Network

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

The Council of Governors will be invited to nominate a Governor observer to attend meetings of the Committee.

Responsible to: Trust Board of Directors
The Equalities and Workforce Committee will provide a briefing note to
flag any key issues to the Board of Directors after each of its meetings and the Chair of the Committee will feed back any urgent issues verbally at the next Board meeting following the committee meeting.

The Committee will provide the Board with a review of its activities and assessment of its effectiveness and value added on an annual basis.

In order for the Equalities and Workforce Committee to fulfil its objectives and fulfil its role for the Board of Directors there needs to be a very close working relationship between the Equalities and Workforce Committee, the Quality Committee the Audit Committee.

The Equalities and Workforce Committee will provide a report to the Audit Committee at each regular quarterly meeting on key issues arising, with a particular focus on risk and where there are concerns over the management of risk or variations and changes to the way risks are being managed. The feedback should cover any significant areas of risk or gaps in controls or assurance.

The Committee will consider the effectiveness of these arrangements as part of its annual review and report to the Board.

The Deputy Director, HR, will act as Secretary to the Committee, working with the Deputy Director, Corporate Governance to ensure alignment across the different Committees.

The Committee will meet quarterly, although there may be a requirement to meet more frequently at times during the year in order to meet its objectives. There may be a need to convene the committee at very short notice or virtually and to make decisions via email where this is required at very short notice – such arrangements will be established in principle by the committee with the approval of the Board.

The meeting will be quorate when there are a total of two Board Directors present.

The minutes and papers of meetings will be kept and archived by the Committee Secretary.

The Chair and Secretary will review the effectiveness of the committee after each meeting.

The Terms of Reference will be reviewed initially within six months and at then at 12 months with a view to the Board deciding whether the Committee should continue.

Executive groups and committees relating to the Equalities and Workforce Committee include:

- Joint Staff Committee
- Education and Development Committee
- Equalities, Diversity and Inclusion Group (previously the Equalities and Human Rights Group)
REPORT TO THE TRUST BOARD: PUBLIC

19 December 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 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 although reductions have been achieved in recent months; 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 across LSLC have taken place and discussions continue with all commissioners. The NHSE contract in 2017/18 has not established workable QIPP schemes and NHSE have agreed to provide their alternative proposals and plans.

There are on-going developments with both Croydon and Lambeth Alliances which will continue to be shared as details are confirmed ahead of 2018/19. Southwark Local Authority has communicated a significant reduction in CAMHS funding as well as a change to section 75 arrangements.

Continued progress is evident with our emergency preparedness.
PERFORMANCE REPORT

1. Report Format and Summary

2. NHS Improvement Indicators

2.1 NHSI Indicators: Access, Effectiveness and Quality

2.1.1 Home Treatment Team Gatekeeping

2.1.2 Early Intervention in Psychosis 2-week standard

2.1.3 IAPT Waiting Times

2.1.4 IAPT Recovery

2.1.5 IAPT Payment By Results

2.1.6 7 Day Follow Up

2.1.7 Improving Physical Healthcare

2.2 Business Intelligence

2.2.1 Data Quality for Mental Health Services Data Set submissions

2.2.2 Improving the clinical service directory

3 Operational Performance and Activity

3.1 In-Patient Activity and Performance

3.1.1 Length of Stay: Acute Care Pathway

3.1.2 LSLC Admissions

3.1.3 Delayed Transfers of Care

3.2 Community Activity & Performance

3.2.1 A&E Mental Health Liaison

3.2.2 Community Teams

3.2.3 Community Team Quality and Effectiveness Trigger Tool (QUESTT)

4. CAG Performance Reviews Summary

4.1 Training

4.1.1 Mandatory Training Compliance (November 2017)

4.1.2 Immediate Life Support

4.1.3 PSTS Teamwork

4.1.4 Training Exclusions

4.1.5 Risk Management for Senior Managers

5. Commissioning

5.1 Commissioner-related Quality Impact Assessments (QIAs)

5.2 Commissioning Programmes 2017-18

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

5.2.2 Commissioning for Quality and Innovation (CQUIN) Schemes

6. Programme Management Office (PMO)

6.1 Cost Improvement Programme (CIP)

6.1.1 Recovery Planning

7. Emergency Planning

8. Conclusion

Appendix 1 - Glossary

Appendix A – October Performance Dashboard
Appendix B – October 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
- QIPP – Southwark Placements, NHS England Specialist Services, Lewisham Community Services
- 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 November 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.
2.1.2 Early Intervention in Psychosis 2-week standard

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
The Trust has consistently achieved in excess of the 6 week and 18 week targets this financial year. The Trust is judged by its regulators and NHS England based upon information produced by NHS Digital. Each month, the Trust provides two data submissions conforming to the required data standards, one (Primary) is for the preceding month and the second is the finalised data (Refresh) for the earlier month. NHS Digital figures are represented by the green line in the chart. Local figures (in blue) are a snapshot of the live system which will be different due to rounding practices used by NHS Digital and late data entry from clinical services. 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.

- The Lewisham IAPT service has been changing its structure as a result of the 2017/18 QIPP. The 6 week standard has not been met in Lewisham for the last 4 months, with performance dropping in October. This is being reviewed and addressed by the team as the changes are established.

- 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 improved reporting processes, in addition to initiating an internal audit to review all IAPT submissions.

### 2.1.4 IAPT Recovery

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

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

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.

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, Early intervention in psychosis (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 version 3 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.
3 Operational Performance and Activity

3.1 In-Patient Activity and Performance
In order to improve the tracking of performance against contract, the following five run charts show the performance of the adult acute inpatient services for LSLC patients against the LSLC contract values. In order to enable monthly comparison, the charts show the average number of occupied beds during the month. There are 340 beds across all adult acute wards (EI, triage, acute, PICU), with approximately 20 beds being filled with non-LSLC inpatients.

During Q4 17/18, it is anticipated that the number of beds in use will reduce below 340 and subsequent reductions in the chart will reflect the creation of spare capacity and thereby increased resilience. The reduction achieved through 2017 has supported the closure of Bridge House and Foxley Lane; future reductions in the chart does not mean further beds plan to be closed in 2018.

The charts show LSLC performance on a monthly basis for 19 months from April 2016 to October 2017 with the contract trajectory included through to March 2018. It can be seen that the contracted level of activity was revised upwards in April 2017 as part of the 1718 planning. Figures include foreign patients for which a further accounting adjustment is made (usually reducing the activity by c. 2%). The data excludes leave and includes all overspill.

Of particular note is the excess in Lambeth (c. 25% excess in Q2) and Lewisham (c. 15% excess in Q2) and recovery plans have been devised in alignment with the overall Large Scale Initiative. A forecast year end position and risk share has been confirmed and recovery trajectories are being finalised - future charts will reference the revised trajectory. Current data indicates the recovery plans are reducing bed usage.

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 plan for 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 end of November, the colours represent the split between Acute and PICU beds.
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:

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<td>Lewisham</td>
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<td>Southwark</td>
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Types of projects:

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<td>Improving communication across boundaries</td>
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<td>Reducing risk</td>
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3.1.1 Length of Stay: 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 (wk1, December) 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 with Croydon, Lambeth and Lewisham CCGs all having 12 patients 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.
LSLC admit daily equiv from Apr16

Lambeth admit daily equiv from Apr16

Southwark admit daily equiv from Apr16

Lewisham admit daily equiv from Apr16
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 October, the Trust recorded 619 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. 11 – October Delayed Transfers of Care, Lost Bed Days by Local Authority

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 34% above indicative activity plans. Please note: Lambeth data is not available for October at the time of writing.
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 November 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 – Nov 17

Fig. 14  Early Intervention caseload, referrals and discharges Apr 16 – Nov 17
3.2.3 Community Team Quality and Effectiveness Trigger Tool (QUESTT)

In order to provide insight into the pressures and risks in community teams a community version of the inpatient QUESTT is being developed. In order to avoid adding to the administrative burden of clinical teams, the report is only incorporating information reported automatically. The first version will be produced in January (piloted within MHOAD) with the current parameters from:

<table>
<thead>
<tr>
<th>Domain</th>
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<td>Patient Experience</td>
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<td>ESR</td>
</tr>
<tr>
<td></td>
<td>Starters</td>
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</tr>
<tr>
<td></td>
<td>Leavers</td>
<td>ESR</td>
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<td></td>
<td>Turnover</td>
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<tr>
<td></td>
<td>Appraisal</td>
<td>LEAP</td>
</tr>
<tr>
<td></td>
<td>Training Compliance</td>
<td>LEAP</td>
</tr>
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<td>Estates Environment</td>
<td>Outstanding Issues on PlanetFM</td>
<td>Planet FM</td>
</tr>
<tr>
<td>Activity</td>
<td>Number patients on CPA</td>
<td>ePJS</td>
</tr>
<tr>
<td></td>
<td>Activity vs Plan</td>
<td>ePJS</td>
</tr>
<tr>
<td></td>
<td>Number on waiting list</td>
<td>ePJS</td>
</tr>
<tr>
<td></td>
<td>Waiting Times</td>
<td>ePJS</td>
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<tr>
<td></td>
<td>Dementia Diagnosis Rate</td>
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<tr>
<td>Access</td>
<td>Number on waiting list</td>
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<tr>
<td></td>
<td>Waiting times</td>
<td>ePJS</td>
</tr>
<tr>
<td></td>
<td>Referral to Assessment Time</td>
<td>ePJS</td>
</tr>
<tr>
<td></td>
<td>Referral to Diagnosis time</td>
<td>ePJS</td>
</tr>
<tr>
<td></td>
<td>Referral to Treatment time</td>
<td>ePJS</td>
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<tr>
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<td>Discharges by Diagnosis by ICD10</td>
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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
- Forward planning for leave over the Christmas period

4.1 Training

4.1.1 Mandatory Training Compliance (November 2017)
Overall mandatory training compliance dropped c. 2.5% in the past two months although performance remains stronger than the beginning of the year.

4.1.2 Immediate Life Support
Poor compliance with Immediate Life Support training is a particular concern. This training is required of all ward-based nurses and doctors as well as any staff on the Duty Senior Nurse rota. There are currently 300 staff who are non-compliant with this training. Additional training sessions have been scheduled between now and March 2018 so that the Trust can reach 85% compliance with this safety critical training.

4.1.3 PSTS Teamwork
Compliance with PSTS Teamwork has also fallen in the past two months. September, October and November are always challenging months for PSTS compliance due to the volume of new recruits requiring intensive training. This has been exacerbated by the necessity to reduce class sizes following the closure of the Community Centre at Bethlem Hospital. Measures to alleviate this pressure point are being sought for 2018. Additional dates for both the five-day initial training and three-day refresher course have been scheduled for the remainder of the financial year to address the current compliance gap.

4.1.4 Training Exclusions
Both resuscitation and PSTS training require a high level of physical activity. Individuals who are unable to complete the training because they are temporarily unable to perform physical duties must be assessed by occupational health. The individual’s manager must also inform Education & Development of the nature and likely duration of the exclusion which will be recorded on LEAP. Some of the non-compliance with resuscitation and PSTS training may be the result of exclusions which have not been recorded centrally and E&D staff are working with CAGs to address this problem.

4.1.5 Risk Management for Senior Managers
As a result of feedback from senior colleagues, the audience for Risk Management for Senior Managers was changed in October. This training is now a once-only requirement for all psychologists at band 8b and above and all other staff at band 8a and above. This has resulted in a decrease in compliance as some senior managers were previously excluded from the audience.
Fig. 15  Mandatory Training Tier 1 Levels A & B

Page 86 of 121
5. Commissioning

The 1819 contract refresh is taking place with meetings progressing with LSLC. NHSE commissioners continue to develop their plans for 1819 and there continues to be a significant gap in the on-going 1718 QIPP programme which remains the priority for that contract. 2018/19 will be the second year of the existing two year contracts and broadly, commissioners have confirmed a consistent approach regarding their plans and priorities for mental health services. However, discussions have highlighted limited or no QIPP plans to meet the plans envisaged for 1819, primarily as there are no plans to close adult acute inpatient wards in 1819. Escalation meetings with the Chief Operating Officer have taken place across LSLC supported by the Director of Finance and Chief Financial Officer. At the time of writing, Lambeth and Southwark contracts are likely to be resolved at this level, whilst further escalation to the Chief Executive is scheduled for Lewisham in order to agree a final contract envelope and QIPP plan. There is a clinical escalation for Croydon to the Medical and Nursing Director alongside CCG clinical leads so that the impact of the CCG’s QIPP proposal to operate at 100% bed utilisation can be further reviewed.

The refresh discussions continue to adhere to the following principles:

- All QIPP schemes will be managed using the PMO process, including a QIA.
- Investment for 5YFV initiatives will be clearly identified and not result in a reduction of funding for core services.
- Where commissioners are unable to propose viable QIPP schemes and there remains a financial challenge, we will support them to prioritise disinvestment in services and clarify the associated impact on performance.

Croydon CCG continues to face a significant financial challenge. The Trust continues to seek confirmation of the Croydon CCG position 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 priority investment areas for the 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.

Croydon’s transformation planning is now developing programmes to cover all ages and the CCG and Croydon Health Services NHS Trust intend to extend the scope of the OBC Alliance to adults of all ages. The SLaM Executive has expressed their lack of confidence in the ability of the programme to encompass this expansion due to the challenges co-ordinating the OBC >65 programme. For a number of months, the Croydon Older Adult Outcomes Based Commissioning (OBC) Alliance and the Mental Health commissioning team have discussed the need to improve co-ordination and alignment with the existing Mental Health Programme Board acting as a focal point for all mental health proposals. An improvement has not materialised.

A contractual mechanism is being devised that will enable members of the Alliance to cover different age ranges and this will be shared with the SLaM Board once complete so that a decision can be made regarding the structure of the Croydon Alliance.

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 supported Trust requirements for investment and are reducing the initial £1 million devaluation of the contract accordingly. Discussions are on-going 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. Alternative options are being explored.

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 are a number of pressure points in Southwark services: in addition to the focus on IAPT (see performance section, 2.1.4), there is continued pressure on placements following the QIPP adjustment and whilst actions have reduced the amount of growth, the outturn position is being used to support stability for future plans.

In September, Southwark Council communicated their intention to remove £1.3 million of CAMHS services in January 2018. Following representations from the Trust and CCG, funding has been confirmed through to the end of the March 2018 and it is hoped to better understand the local authority consultation plans and intentions. The CAMHS CAG has developed relevant impact assessments as well as commencing contingency planning. The local authority has also served notice to Southwark CCG on the section 75 agreement in relation to mental health, which will therefore end on 31 March 2018. A new way of working will need to be established and further updates to the board will be provided as this work develops.

A meeting was held with NHS England to review 2017/18 QIPP schemes. The commissioners recognised that the CAMHS QIPP scheme had failed following a lack of agreement to proceed with the service redesign in Kent. A replacement QIPP scheme had been identified based on the principles of the national repatriation CQUIN. However, it is becoming apparent that these actions will not be cash releasing. SLaM representatives confirmed the intention 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) although it was agreed to delay doing this for a short period to allow time for commissioners to review and explain how the QIPP schemes for both CAMHS and PM&IC are intended to operate.

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.

It is pleasing to be able to report that approval was granted at JOSC on 6th November to redesign the older adult 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.
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:

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<th>Rating</th>
<th>Definition</th>
<th>£'000s</th>
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<td>Red</td>
<td>Requires significant work</td>
<td>2,651</td>
</tr>
<tr>
<td>Amber</td>
<td>Requires some work</td>
<td>600</td>
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<tr>
<td>Green</td>
<td>Requires little work</td>
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<td>Blue</td>
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The QIPP risk dashboard is below:
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<th>QIPP plan</th>
<th>progress</th>
<th>CAG</th>
<th>Value (£)</th>
<th>RAG</th>
<th>Forecast (£)</th>
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<td>Southwark</td>
<td>Residential placements structure of teams</td>
<td>Action plans agreed, case being prepared for discussion with commissioner</td>
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<td>800,000</td>
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<td>Lewisham Community Teams - All Team</td>
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<td>NHS England</td>
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<td>NHSE plans not produced, full amount at risk</td>
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<td></td>
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<td>Tier 4 Acute Adolescent Inpatient Kent</td>
<td>○ NHSE Kent, Surrey, Sussex have not engaged proactively with QIPP</td>
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<td>(delayed transfers of care) - will require a</td>
<td>○ This results in reduced impact of CIP as £2.7m OBD cost is taken as</td>
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<td>○ this is already accounted for in financial plan.</td>
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<td>QIPP18</td>
<td>NHS England</td>
<td>Secure &amp; Specialised MH - secure male MI</td>
<td>CAG confirmed action is complete. SLaM agreement with NHSE to reduce</td>
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<td>(FYE 16/17)</td>
<td>QIPP target with each repatriation must be tested against SLP finance</td>
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<td>arrangements agree final transition model with CCG</td>
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<td>MOHA</td>
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<td>254,000</td>
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<td>88,000</td>
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<td></td>
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<td>MOHA plus extension of Adult IAPT)</td>
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<td>CAMHS</td>
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<td>50,000</td>
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<tr>
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<td>MOHA</td>
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<td>Accounts</td>
<td>Lambeth</td>
<td>MOHA - Continuing Care</td>
<td>Complete</td>
<td>MOHA</td>
<td>362,580</td>
<td>362,580</td>
<td>362,580</td>
</tr>
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</table>

**Fig. 16 QIPP dashboard**
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 additional CIP target of £1.1m has been allocated to the CAG’s cost saving to the compared AIP target. The difference is due to the 1.5m in the forecast variance, £0.2m lock-in has been recognised in PME and £0.2m in RAP.

The forecast variance is principally due to the reallocation of £0.2m in relation to the additional schemes: Additional £0.2m in CIP and £0.2m in RAP. There remains a significant degree of uncertainty with the RAP and CIP schemes in particular.

All of the unidentified schemes have been reallocated to the CAG’s target as a forecast value which reflects the write off of the CIP (self-funded) and the cost of additional schemes. The £1.1m is over and above the CIP target which has been reallocated to Trust wide ambitions.

![Fig. 17 Trust October CIP position](image-url)
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 overspend 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 overspend 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 has been 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.

8. Conclusion
The Trust continues to meet the 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 although reductions have been achieved in recent months; 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 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.

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 across LSLC have taken place and discussions continue with all commissioners. The NHSE contract in 2017/18 has not established workable QIPP schemes and NHSE have agreed to provide their alternative proposals and plans.

There are on-going developments with both Croydon and Lambeth Alliances which will be presented to the Committee and Board as soon as details are confirmed. Southwark Council has communicated a significant reduction in CAMHS funding as well as a change to section 75 arrangements.

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.

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

<table>
<thead>
<tr>
<th>Abbreviation</th>
<th>Description</th>
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<tbody>
<tr>
<td>Ascom</td>
<td>Alarm / communications system supplied by Ascom UK, a telecommunications company</td>
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<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>
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<tr>
<td>CBT</td>
<td>Cognitive Behavioural Therapy (CBTp is CBT of psychosis)</td>
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<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>
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<tr>
<td>CIP</td>
<td>Cost Improvement Programme</td>
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<tr>
<td>CPA</td>
<td>Care Programme Approach</td>
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<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>
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<tr>
<td>CYP</td>
<td>Children &amp; Young People</td>
</tr>
<tr>
<td>DBT</td>
<td>Dialectical Behaviour Therapy</td>
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<tr>
<td>DTOC</td>
<td>Delayed Transfers of Care</td>
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<tr>
<td>EI</td>
<td>Early Intervention: First Episode Psychosis</td>
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<tr>
<td>ePJS</td>
<td>Electronic Patient Journey System: Clinical records system</td>
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<tr>
<td>EPRR</td>
<td>Emergency Preparedness, Resilience and Response</td>
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<tr>
<td>GSTT</td>
<td>Guys &amp; ST Thomas’ NHS Foundation Trust</td>
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<tr>
<td>HTT</td>
<td>Home Treatment Team</td>
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<tr>
<td>IAPT</td>
<td>Improving Access to Psychological Therapies</td>
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<tr>
<td>JOSC</td>
<td>Joint Overview and Scrutiny Committee</td>
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<td>LSLC</td>
<td>Lambeth, Southwark, Lewisham &amp; Croydon (CCGs)</td>
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<td>MHOA</td>
<td>Mental Health of Older Adults</td>
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<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>
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<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>
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<tr>
<td>NHSP</td>
<td>NHS Professionals</td>
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<tr>
<td>NICE</td>
<td>National Institute for Health and Care Excellence: provides national guidance and advice to improve health and social care</td>
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<tr>
<td>OAP</td>
<td>Out of Area Placements</td>
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<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>
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<tr>
<td>PICU</td>
<td>Psychiatric Intensive Care Unit</td>
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<tr>
<td>PMF</td>
<td>Performance Management Framework</td>
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<td>PMO</td>
<td>Programme Management Office</td>
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<tr>
<td>QIA</td>
<td>Quality Impact Assessment</td>
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<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>
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<td>SEL</td>
<td>South East London</td>
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<td>Abbreviation</td>
<td>Description</td>
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<td>--------------</td>
<td>--------------------------------------------------</td>
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<tr>
<td>SOF</td>
<td>Single Oversight Framework: NHSI assurance and performance mechanism</td>
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<tr>
<td>SPC</td>
<td>Statistical Process Control</td>
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<td>STP</td>
<td>Sustainability and Transformation Partnerships</td>
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<td>SWL</td>
<td>South West London</td>
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<td>YTD</td>
<td>Year to Date</td>
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Appendix A Performance Management Framework Trust Summary

Please refer to Board Finance Report

Workforce

Please refer to Board Finance Report

Activity

Adult OBD Against Monitor Plan

(excl. Private Overspill)

Acute CAG overspill (April - November)
Oct-17

Appendix A Performance Management Framework Trust Summary

Finance & CIPs

Appendix A Performance Management Framework Trust Summary

7 Day Follow Up (Target 95%)

- Achieved
- Missed

No. Missed

48.5% of patients followed up within 7 days of discharge
0.0% of patients lost a CPA review within 12 months

38.8% variation to the previous month

Early Intervention in First Episode Psychosis

Completed Pathways (50% target) by Month (in arrears)

Customer (Patient & Commissioners)

Mandatory Training

- Tier 1A
- Tier 1B
- Clinical Risk

Training Completions (in arrears)
QSC Quality Dashboard

Period: October (Month 9) 2017
Circulation: Board Circulation December

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. There was an increase in Mandatory Training courses falling into the Red rating from 1 to 4. 1 has since improved substantially in recent data. A number of data items were being validated at the time of writing.

Safe

QUESTT incorporates the following Metrics:

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

<table>
<thead>
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<th>Total QUESTT Scores by Ward &amp; Home Treatment Teams, October 2017</th>
</tr>
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<tbody>
<tr>
<td>Safe</td>
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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 2016. 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%).
REPORT TO THE TRUST BOARD: PUBLIC
19 DECEMBER 2017

Title | Finance Report As At 19th December 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 30th November 2017 (month 8). The summary financial statement and calculation of the Use of Resource rating from the NHSI month 8 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 8 ytd, the Trust had made a surplus of £0.9m, a favourable variance of £2m against its month 8 control total. This represents a small adverse movement in the month.

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

A number of actions to correct the run rate position are underway through Portfolio Board, CEO assurance and PACMAN sessions. These have included the transfer of drug budgets to Pharmacy and NCA income targets to the Chief Operating Officer which have impacted on their respective positions this month. The focus has been on impact, deliverability of targets and the 2018/19 recurrent position. However, there remains a significant requirement for non recurrent actions in order to deliver the position.

NHSI have recently announced that an STF bonus scheme will be available for Trusts who meet or exceed their control totals as per 2016/17. NHSI expects to fully distribute the £1.8bn related to STF funding and reward those Trusts who meet and/or exceed their control totals. It is probable that a significant number of Trusts will miss their control totals in 2017/18. As a result incentives could be significant for Trusts who can overperform. All STF bonus incentives are fully non recurrent so have no impact on recurrent I&E but have a positive impact on cash. STF incentives aren’t available to fund additional revenue expenditure. The Trust’s current forecast assumes that the core STF funding will be received but no 2017/18 bonus has been assumed.

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 £56m in November (a £17m favourable variance from plan). This position is driven by unplanned 2016/17 STF funding, capital slippage and property sales and is expected to remain strong throughout the remainder of the year.

The Trust has invested £3.3m of capital expenditure to date (£7.2m below plan) but expects to
spend £11m capital in the year (£9m below plan) having rolled forward £7.7m of Douglas Bennett House investment.

The Trust is currently rated by NHSI as a 1 against use of resources (where 1 is best out of a 1-4 range – see Table 2). The rating improved again this month (an improvement in the capital service cover). The Trust retains good ratings against liquidity (cash position), distance from financial plan 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 £2.5m after 8 months. Through the introduction of a range of measures, overspill numbers fell in October to just 1 bed with this position being maintained through November. The target trajectory aims to contain the Trust’s financial exposure to £2.5m by maintaining overspill at an average of 3 beds 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 8, the Trust had generated CIP savings of £14.8m. Due to the month 7 property disposals, the Trust remains ahead of its NHSI CIP plan by £0.4m. 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 recurring shortfall from the original £27m target is £10m. The Trust is developing in year plans to close its forecast CIP gap but will be reliant upon non recurrent measures to ensure this can happen.

- Southwark placements remain a concern and are £1.4m overspent (before application of risk shares and the 17/18 QIPP). 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 and form a key part of the current contract negotiations for 2018/19. The Trust is now forecasting an overall deficit of £2m 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 8 months is c17% 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 33%. 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 £1.9m more than employing equivalent permanent staff.

- 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 which are being raised as part of the 2018/19 CCG/Local Authority contract discussions.

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. The dispute has been escalated to respective CFOS/CEOs for resolution.

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 likely this too will be escalated to Chief Officer level given the value and principles at stake.

3) Forecast

At Month 8, 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 review of CAG and infrastructure positions and a further release of balance sheet provisions the Trust has identified financial risks totalling £6.4m by year end (£6.5m at month 7). This is made up of –

- £7.3m adverse CAG positions driven primarily by Psychosis and ACP (overspill, placement and ward costs)
- £6.2m adverse infrastructure positions (£3.7m unmet CIP, £2.5m expenditure overspend). The main areas of concern are estates (£2.5m) and pharmacy (£1.6m)
- £7.1m favourable central corporate position mainly related to balance sheet adjustments, restructuring underspends, reserve releases and property disposals of £4.0m

The total forecast assumes CIP recovery of £3.8m and QIPP recovery of £1.1m which is likely to be challenging to achieve. In the event that there is slippage on CIP / QIPP recovery, additional balance sheet/non recurrent releases would be required.

Non recurrent items reflect an equivalent underlying deficit position and will translate into an additional pressure to be addressed in 2018/19 in order to break even. 2018/19 will continue to be financially challenging for SLaM and an underlying deficit brought forward from 2017/18 will clearly worsen that position. Hence we are focussing on increasing the delivery of recurrent schemes this year to reduce the reliance on non-recurrent items.
### 1) Financial Summary

#### 1. Health Centre

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<thead>
<tr>
<th>Service Analysis</th>
<th>Full Year Live Budgets (£)</th>
<th>Monthly Figures</th>
<th>Year to Date Figures</th>
<th>Variance Last Month (£)</th>
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<tr>
<td><strong>Area</strong></td>
<td><strong>2017/18 Mth 3</strong></td>
<td><strong>2017/18 Mth 4</strong></td>
<td><strong>2017/18 Mth 5</strong></td>
<td><strong>2017/18 Mth 6</strong></td>
</tr>
</tbody>
</table>
| **CAGs**         | 831                              | 322               | 895              | (151)                  | 888                      | (108)                | 4,437 (

#### 1.1 Key Cost Drivers

**Area** | **2017/18 Mth 3 Variance £000** | **2017/18 Mth 4 Variance £000** | **2017/18 Mth 5 Variance £000** | **2017/18 Mth 6 Variance £000** | **2017/18 Mth 7 Variance £000** | **2017/18 Mth 8 Variance £000** | **2017/18 Total Variance £000** |
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<td>Ward Nursing*</td>
<td>270</td>
<td>203</td>
<td>117</td>
<td>132</td>
<td>57</td>
<td>160</td>
<td>1,099 (</td>
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<tr>
<td>Agency Premium @ 20%</td>
<td>223</td>
<td>281</td>
<td>270</td>
<td>167</td>
<td>216</td>
<td>252</td>
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<tr>
<td>Total</td>
<td>447</td>
<td>1,822</td>
<td>851</td>
<td>490</td>
<td>(537)</td>
<td>1,614</td>
<td>7,365 (</td>
</tr>
</tbody>
</table>

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

### 2) Area

**Area** | **2017/18 Mth 3 Variance £000** | **2017/18 Mth 4 Variance £000** | **2017/18 Mth 5 Variance £000** | **2017/18 Mth 6 Variance £000** | **2017/18 Mth 7 Variance £000** | **2017/18 Mth 8 Variance £000** | **2017/18 Total Variance £000** |
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</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 November, a similar figure to the previous month and in line with the revised plan. The use of overspill beds has resulted in a cost pressure, after application of risk shares, of £2.5m after 8 months. The forecast deficit of £2.5m deficit caused by overspill assumes that the Trust will now use a monthly average of 3 overspill beds over the remainder of the year compared to an average of 22 beds over the first 8 months. This is a tight position to maintain but overspill has fallen and remained at a low level for 2 months now with intensive work being undertaken under the QI initiative and a new policy to no longer fund overspill above CCG funded levels.

- **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 8 months although the target is phased to decrease over the remainder of the year. The spend in October of £1.5m was above the ytd monthly average with a significant increase in medical agency. 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.

  Although included above, medical agency also has its own NHSI target which it is not meeting. Based on current rates, expenditure is forecast to be £3.6m putting it 56% above target at year end.

- **Ward/Unit Nursing Costs**

  At month 8 ward nursing costs overspent by £160k (£1.1m 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. Delays in converting 2 of the Triage Wards have resulted in overspends of £0.5m after 8 months. Lewisham Triage is still yet to convert and is overspending at a rate of £40k per month. 2 of the PICUs are also continuing to overspend at levels difficult to sustain going forward (a combined 19% over on pay budgets compared to just 2% on the other 2 PICUs).
• **Cost per Case/Cost and Volume Income**

The overall position improved this month with B&D income continuing to perform strongly whilst there were improvements across both PMIC and CAMHS —

- Psychosis – Heather Close is now £143k below target levels following an increase in the income target and a continuing number of unused cost per case beds. It is also £157k over on expenditure budgets. In addition the Psychosis Unit is £255k below income target with further income at risk due to late recovery of debt 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 Medicine & Integrated Care – improvements in income across Neuro Psychiatry outpatients and Affective Disorders helped to stabilise the position this month. Eating Disorders outpatient and inpatient continue to underperform. An NHSE QIPP has been applied to the inpatient service but 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 – there was an improvement in the month across both inpatient and outpatient. Bed occupancy improved on inpatient whilst a review of income accruals this month resulted in an improvement in the outpatient position. As with PMIC, 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 8 £’000</th>
<th>Actual Invoiced At Month 8 £’000</th>
<th>Surplus/Deficit At Month 8 £’000</th>
<th>Surplus/Deficit At Month 7 £’000</th>
</tr>
</thead>
<tbody>
<tr>
<td>Psychosis</td>
<td>5,303</td>
<td>4,937</td>
<td>366</td>
<td>334</td>
</tr>
<tr>
<td>Behavioural &amp; Developmental</td>
<td>15,416</td>
<td>16,301</td>
<td>(884)</td>
<td>(669)</td>
</tr>
<tr>
<td>Psych Med &amp; Integrated Care</td>
<td>13,668</td>
<td>13,242</td>
<td>427</td>
<td>417</td>
</tr>
<tr>
<td>CAMHS</td>
<td>18,207</td>
<td>18,053</td>
<td>154</td>
<td>430</td>
</tr>
<tr>
<td>MHOA</td>
<td>40</td>
<td>71</td>
<td>(31)</td>
<td>(27)</td>
</tr>
<tr>
<td><strong>TOTAL</strong></td>
<td><strong>52,634</strong></td>
<td><strong>52,604</strong></td>
<td><strong>30</strong></td>
<td><strong>485</strong></td>
</tr>
</tbody>
</table>

• **Complex Placements**

Lambeth placements remain within budget. However Lewisham are overspending (£265k 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 £1.4m is split between the CCG (£0.8m) 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 clear that the financial targets will not be met this year. The forecast overspend on the CCG element of placements is now estimated at £2m (including the £800k QIPP)

Glossary

<table>
<thead>
<tr>
<th>AMH</th>
<th>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</th>
</tr>
</thead>
<tbody>
<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>
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<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 organisations 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>
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<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>
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<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>
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<tr>
<td>STF</td>
<td>Sustainability &amp; Transformation Fund that is intended to support providers to move to a sustainable financial footing</td>
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<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>
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<td>YTD</td>
<td>Year To Date</td>
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</tbody>
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### Income and Expenditure

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<tr>
<th></th>
<th>YTD</th>
<th>YTD Plan</th>
<th>Forecast/School</th>
<th>FY Plan</th>
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</thead>
<tbody>
<tr>
<td>EBITDA</td>
<td>£6.5m</td>
<td>£10.6m</td>
<td>£13.2m</td>
<td>£19.0m</td>
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<td>I&amp;E (deficit) surplus</td>
<td>£0.2m</td>
<td>£1.4m</td>
<td>£2.4m</td>
<td>£2.5m</td>
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<tr>
<td>Debt service cover</td>
<td>1.67</td>
<td>2.50</td>
<td>2.21</td>
<td>3.11</td>
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</table>

### Financial Position

#### Key Financials

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<th>YTD</th>
<th>YTD Plan</th>
<th>Forecast/School</th>
<th>FY Plan</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cumulative EBITDA</td>
<td>2.6%</td>
<td>4.2%</td>
<td>3.5%</td>
<td>5.3%</td>
</tr>
<tr>
<td>Debts service cover</td>
<td>1.2%</td>
<td>2.4%</td>
<td>2.0%</td>
<td>3.1%</td>
</tr>
</tbody>
</table>

### Commentary

1. At Month 8 ytd the Trust has a surplus of £0.9m, a favourable variance of £2m against the NHSI control total.

2. The underlying position remains as before, driven by a combination of cost pressures, particularly acute overspill, complex placements and unset CIPs and QIPPs.

3. A number of actions to correct the overspill position are underway through Portfolio Board, CEO assurance and PACMAN sessions. The focus has been on impact, deliverability of targets and the 2018/19 recurrent position. However, there remains a significant requirement for non recurrent actions in order to deliver the position.

4. NHSI has recently announced that an STF bonus scheme will be available for Trusts who meet or exceed their control requirement. The Trust’s current forecast assumes that the core STF funding will be received but no other bonus has been assumed.

5. The Trust has generated CIP savings of £14.8m. Due to the month 7 property disposals the Trust remains ahead of its NHSI forecast.

6. The use of acute overspill beds has resulted in a cost pressure, after application of risk shares, of £2.5m after 8 months. Through the introduction of a range of measures, overspill numbers fell to a new low in October of just 1 bed with this position being maintained.

7. Southwark placements remain a concern and are £1.4m overspent (before application of risk shares and the 17/18 QIPP). This budget is also subject to a CCG QIPP of £800k.

8. The Trust is currently exceeding its NHSI medical agency target by 33%. 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.

9. CCG and NHSI QIPP schemes total £10m in 17/18 plan. The CCG schemes are aimed primarily at reductions in Adult/MHOA acute occupied bed days (obds) and complex placements and changes to community services. 3 of the CCGs are above their contracted adult bed numbers and this is impacting on the delivery of their QIPP schemes. There are also high risks attached to the Southwark placements QIPP of £800k which are being raised as part of the 2018/19 CCG/LA contract discussions.

10. The Trust is currently exceeding its NHSI medical agency target by 33%. 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.

11. CCG and NHSI QIPP schemes total £10m in the 17/18 plan. The CCG schemes are aimed primarily at reductions in Adult/MHOA acute occupied bed days (obds) and complex placements and changes to community services. 3 of the CCGs are above their contracted adult bed numbers and this is impacting on the delivery of their QIPP schemes. There are also high risks attached to the Southwark placements QIPP of £800k which are being raised as part of the 2018/19 CCG/LA contract discussions.

12. The NHSI QIPP schemes also involve a reduction in beds across Forensic, CAMHS and Eating Disorder. To date no agreement has been reached as to how these QIPPs will be delivered and it is likely this will be escalated to Chief Officer level given the value and principles at stake.

### Key Financial Drivers

- **Performance v CIP - £0.4m above NHSI Plan - 3% > target** (Inc. profits on sale of assets & lock-ins)
- **Ward Nursing - £1.1m overspent**
- **Acute Overcap - £3m overspent excluding impact of risk share**
- **Complex/Non Secure Placements - £1.7m overspent excluding impact of risk share & Swk QIPP**
- **Cost per Case/Cost & Volume - £0.03m < target**

### Other Metrics

- Forecast HCP less than 2 in next 12 months
- Better payment practice (same NHS by value)
- Cash at bank and in hand

### Capital spend against plan

- **£55.8m**
- **6%**
- **55%**
### Table 1

**The South London and Maudsley NHS Foundation Trust - Operating Budgets**

<table>
<thead>
<tr>
<th>Service Analysis</th>
<th>Full Year Live Budgets (£)</th>
<th>Year To Date Figures</th>
<th>Monthly Figures</th>
<th>Variance Last Month (£)</th>
</tr>
</thead>
<tbody>
<tr>
<td>21. Psychosis</td>
<td>48,311,600</td>
<td>1,713,800</td>
<td>16,100</td>
<td>1,752,700</td>
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<tr>
<td>22. Acute Care Pathway</td>
<td>44,154,400</td>
<td>3,416,300</td>
<td>208,800</td>
<td>2,813,600</td>
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<tr>
<td>23. P Med &amp; Integrated Care</td>
<td>530,800</td>
<td>(9,500)</td>
<td>21,200</td>
<td>(1,100)</td>
</tr>
<tr>
<td>24. Behavioural And Dev. Psych</td>
<td>486,400</td>
<td>379,400</td>
<td>250,500</td>
<td>2,825,400</td>
</tr>
<tr>
<td>25. Child &amp; Adolescent Service</td>
<td>120,800</td>
<td>(45,500)</td>
<td>(460,400)</td>
<td>372,500</td>
</tr>
<tr>
<td>26. MHAO And Dementia</td>
<td>604,400</td>
<td>20,600</td>
<td>315,200</td>
<td>13,500</td>
</tr>
<tr>
<td>27. Addictions</td>
<td>4,700</td>
<td>4,700</td>
<td>97,500</td>
<td>92,800</td>
</tr>
<tr>
<td>28. Critical Support Services</td>
<td>6,286,400</td>
<td>3,050,500</td>
<td>79,200</td>
<td>293,200</td>
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<tr>
<td>29. Infrastructure Directors</td>
<td>53,088,600</td>
<td>4,717,800</td>
<td>290,700</td>
<td>1,779,700</td>
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<tr>
<td>30. Corporate Income</td>
<td>(191,956,600)</td>
<td>(8,500,190)</td>
<td>(3,900)</td>
<td>(510,700)</td>
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<tr>
<td>Operational Deficit</td>
<td>49,422,100</td>
<td>5,776,700</td>
<td>120,800</td>
<td>4,082,400</td>
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<tr>
<td>31. Corporate Other</td>
<td>699,775,999</td>
<td>(3,050,500)</td>
<td>27,800</td>
<td>6,462,800</td>
</tr>
<tr>
<td>32. Understated/Unallocated CIPs</td>
<td>(3,060,016)</td>
<td>(798,400)</td>
<td>816,400</td>
<td>(875,000)</td>
</tr>
<tr>
<td>33. Contingency - planned</td>
<td>1,500,000</td>
<td>125,000</td>
<td>1,000,000</td>
<td>2,984,100</td>
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<tr>
<td>34. General unallocated provision</td>
<td>2,673,100</td>
<td>1,955,400</td>
<td>(2,410,400)</td>
<td>(2,410,400)</td>
</tr>
<tr>
<td>Corporate Other</td>
<td>655,544,100</td>
<td>(7,452,200)</td>
<td>14,500</td>
<td>5,180,300</td>
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<tr>
<td>EBITDA</td>
<td>(19,392,100)</td>
<td>(1,809,800)</td>
<td>270,000</td>
<td>4,145,000</td>
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<tr>
<td>15. Post EBITDA Items</td>
<td>32,400,000</td>
<td>1,305,900</td>
<td>227,000</td>
<td>4,077,000</td>
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<tr>
<td>Trust Financial Position</td>
<td>2,517,900</td>
<td>(522,900)</td>
<td>51,800</td>
<td>2,157,200</td>
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<tr>
<td>Items Not Included in NHSI Target</td>
<td>4,760,000</td>
<td>43,000</td>
<td>75,000</td>
<td>1,939,600</td>
</tr>
<tr>
<td>NHSI Control Total</td>
<td>(2,362,100)</td>
<td>(655,300)</td>
<td>(51,800)</td>
<td>(1,991,400)</td>
</tr>
</tbody>
</table>

### Notes Re MH 3

1. Improvement due to agreed transfer of drug and NCA overspends. Swk placements are 1.4m ytd over excluding risk shares and £950k QIPP. Lewisham placements also overspending (£260k ytd after a £365k QIPP). Overspends on Heather Close (£299k), Psychosis Unit (£253k) & THU (£101k) - income, expenditure and new CPUs. Net £642k ytd of unmet CIPs/QPPs held centrally inc Swk £900k QIPP, low Community QIPP of £164k plus new CIP stretch target of £400k. PICUP income target not being met

2. Reverse acute overspends of £0.5m comprising average of 22 beds over plan. Overspent averaged 1 bed in November. Main concern is Lambeth which has been 30% above contractual plan. Inpatient nursing - £792k overspent inc Gresham 1 - 104k overspent but now rebudgeted, Johnson PICU £151k, Eden PICU £190k and slippage (30.5m) on 2 Triage ward conversions (funding removed but still operating as Triage wards - Lambeth converted in Oct but Lewisham still tbc)

3. ED inpatient NHSE QIPP of £0.3m cannot be saved, income shortfalls in Neuro CIP (£139k) ED CIP (£153k) and other outpatient clinic services. Pressures in A&L teams in Croydon (expected) and Swk (likely - high locgov/cgts costs)

4. Forensic QIPP (£700k) currently being achieved. Decant of Spring Ward yet to impact (c£0.5m cost but now likely to be incurred in 18/19) and unidentifiable savings required to balance the trading account

5. Kent inpatient QIPP impacting plus increased CIP target of £250k - decision to close beds to meet the QIPP has been delayed due to ongoing discussions between NHSE London and NHSE Kent, Surrey and Sussex. Improved outpatient performance this month

6. Large overspends but offset by vacancies in CMHTs (Croydon and Lew), memory and liaison services and good performance on Ann Moss and Cheatham. Position now includes an agreed reduced CIP requirement and transfer of drug and NCA overspends

7. Largey due to CIPs and reduction in LA income which is impacting on the contribution to deficit. Have over £1m of ringfenced Borough underspends

8. Pharmacy services - impacted particularly this month by the agreed overspends on drug budgets (and associated overspends) from CAGs. In addition, unmet drug CPUS and cost of agency staff

9. Includes an additional 16/17 STP incentive payment made in 17/18 of £419k

10. Restructuring underrun in value of assets impacting favorably on capital charges plus profit of disposal of assets (Inglemere and Foxley at £1.5m and Landor Rd at £2.4m)

11. New CIP target

12. Includes 0.5% CQUIN held back against non achievement of STP control total
## NHSI Summary For South London & Maudsley NHS Foundation Trust

### Table 2

#### Key data

<table>
<thead>
<tr>
<th>PLAN</th>
<th>ACT</th>
<th>VAR</th>
<th>PLAN CY</th>
<th>FOT CY</th>
<th>VAR CY</th>
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<td>30/11/2017</td>
<td>30/11/2017</td>
<td>30/11/2017</td>
<td>31/03/2018</td>
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<td>YTD</td>
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<td>Year ending</td>
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<td>£'000</td>
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#### Performance against control total

**Surplus/(deficit) before impairments and transfers**

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<tbody>
<tr>
<td>Plan</td>
<td>Actual</td>
<td>Variance</td>
<td>Plan</td>
<td>Forecast</td>
<td>Variance</td>
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**Adjusted financial performance surplus/(deficit) including STF**

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<td>Plan</td>
<td>Actual</td>
<td>Variance</td>
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<td>Forecast</td>
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**Control total**

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**Performance against control total excluding STF**

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**Adjusted financial performance surplus/(deficit) excluding STF**

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#### Performance against control total excluding STF

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

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### Use of resources risk rating summary

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**Gross capital expenditure**

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**Disposals / other deductions**

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**Charge after additions/deductions**

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**Agency and contract**

**Total agency costs excluding outsourced bank**

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**Agency costs as a percentage of gross payroll costs**

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**Turnover**

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**Risk rating after overrides**

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REPORT TO THE TRUST BOARD: PUBLIC
19 December 2017

<table>
<thead>
<tr>
<th>Title</th>
<th>The NExT Director scheme</th>
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<tr>
<td>Author</td>
<td>Charlotte Hudson, Deputy Director of Corporate Affairs</td>
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<tr>
<td>Accountable Director</td>
<td>Rachel Evans, Director of Corporate Affairs</td>
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Purpose of the paper

The Board is asked to consider the practical guide for NHS Trusts annexed to this paper in relation to NHSI’s NExT Director scheme and, in particular, agree:
- To assign a NED mentor to the NExT Director, helping to shape their personal programme and provide regular feedback;
- To allow access to Board and Committee meetings and papers, including the private sessions of the Board (bound by a confidentiality agreement), including an opportunity to review and analyse meetings to learn with Board members;
- To provide access to training and networking opportunities available to substantive Non-Executive Directors;
- To review after three-four months whether the NExT Director’s observational role at Board / Committee meetings should be extended to a role of active participation.

Executive summary

The NExT Director scheme has been developed by NHS Improvement to support the creation of a pipeline of strong and diverse candidates for future Non-Executive Director roles in the NHS. The scheme provides support to senior people - from groups who are currently under-represented on Trust Boards - to develop the skills and experience necessary to join the NHS in a NED capacity.

As a participating Trust, SLaM has been invited to host a NExT Director for a 12-month period, having been matched with an individual identified as having the attributes to one day become a NED, and who is a “good fit” for the Trust.

An outline for induction and customising the programme for the NExT Director is set out in the attached guidance from NHSI.
The NExT Director scheme - supporting tomorrow's non-executives

A practical guide for NHS host trusts and placements

1. Introduction

1.1. Two of NHS Improvement's (NHSI) key strategic objectives for 2020 are to ‘develop, maintain and enhance effective boards’ and to expect the board of every NHS provider ‘to reflect the diversity of the people it serves’. To help meet these objectives, we have developed the NExT Director scheme to support the creation of a pipeline of strong and diverse candidates for future non-executive director roles in the NHS.

2. What is the NExT Director scheme?

2.1. The NExT Director scheme provides support to senior people from groups who are currently under-represented on trust boards with the skills and expertise necessary to take that final step into the NHS board room. Following a successful pilot in London, the scheme is now being expanded to trusts across the Midlands and East, where the focus will be on supporting women and in London where it will be on people from BAME communities. People with other protected characteristics that are under-represented on boards may also be considered for inclusion in the scheme.

2.2. The NExT Director scheme will give participants a unique insight into the role and responsibilities of being an NHS non-executive director by helping them to bridge gaps in their own experience such as:

- Operating at board level
- Transition from executive to non-executive roles
- Board level exposure in organisations of huge size and complexity
- Gain knowledge of NHS structures and accountability, how the money flows, who the key partners are, where all the regulators fit and the board’s role in quality and safety.

2.3. Individual NExT Directors will be offered a placement with one or more NHS healthcare providers in their area, over a 12 month period and will give them the opportunity to learn first-hand about the challenges and opportunities associated with being a non-executive director (NED) in the NHS today. Each placement will be shaped to meet the individual needs of participants but will include a range of support such as:

- Access to board and committee meetings and papers, including an opportunity to review and analyse meetings to learn with board members, as appropriate;
- The assignment of an experienced NED mentor for the period to help shape the NExT Director's personal programme and provide regular feedback and advice;
• Access to training and networking opportunities available to substantive non-executive directors.

3. The NExT Directors

3.1. The NExT Directors were identified from a range of sources and have been through a selection process by NHSI’s Non-executive Appointments Team to ensure that they have the attributes needed to be a NED one day and that they are willing and able to make the most of the opportunity provided by the scheme. They were then “matched” with participating trusts based on their geography and any service area preferences before being introduced to the trust chair, to ensure they were a good fit for that organisation.

3.2. All NExT Directors have been subject to due diligence checks and have signed the NExT Director Placement Agreement at Annex A before their placement was confirmed.

4. A strong starting point

4.1. There will be a short planning period before any placement starts to give both the NExT Director and their host trust the opportunity to prepare so that the placement gets off to a strong start. Each placement will be different but before starting NExT Directors and their trust should have a high level, shared understanding of what it will offer and the level of commitment the NExT Director will be able to make.

4.2. In this planning period, and before the placement starts, the trust chair should:

• Ensure there is “buy-in” from the whole board and establish some basic rules of engagement that wherever possible are inclusive – ie will the NExT Director have access to confidential sections of board meetings, or be invited to participate in discussions? NB – remember these can always be changed as the relationship between the NExT Director and trust develops over the placement;

• Identify an experienced NED from within the trust to act as mentor to the NExT Director – some host trusts identified more than one mentor but it is important everyone understands who is responsible for what;

• Ensure the NED Mentor meets their NExT Director to explain the rules of engagement and agree the first set of high level outcome based development objectives. The NExT Director should confirm the time commitment they are able to give to the placement, we estimate a minimum of two days a month, whether they have the support of their employer (where appropriate), and confirm their availability for key board / committee dates which for many trusts will be during the day;

• Ensure administrative arrangements to allow NExT Directors to have access to board and committee meetings and papers, as required and to claim travel expenses if required;

• Ask the NExT Director to sign a confidentiality agreement if he / she will have access to confidential board meetings and sub-committees or other sensitive
information. Depending on the level of contributions envisaged by individual NExT Directors consider whether indemnity arrangements would be appropriate;

- Ensure that NExT Directors who will receive sensitive information know how to and are able to protect it properly. This may mean creating a secure email address, providing access to the same IT as NEDs and providing the appropriate Information Governance training;

- Develop a comprehensive local induction programme for the NExT Director. Individual trusts should determine what this will be and how this is delivered, depending on local circumstances, but it could be based on the induction provided to new substantive NEDs, and include information about the key policies and procedures that may be relevant during the NExT Director’s placement; and

- Provide the NExT Director with a tour of the major sites of the trust and an opportunity to meet key members of staff. It is important that he / she is introduced to both the executive and NED team, as well as key members of the trust’s wider management team.

5. NED mentors

5.1. NED mentors are experienced non-executives responsible for making sure their NExT Director is provided with the support they need during their placement and are therefore critical to its success. It is not expected that it will be too time consuming but should include:

- Regular diarised meetings with the NExT Director before and after each board meeting to discuss key issues and observations and answer any questions they may have;

- Regular and timely feedback between mentors and NExT Directors including honest reviews of development objectives. Regularly refresh these objectives and consider establishing a deliverable project - this will ensure the learning experience is targeted and productive. Experiences and exposures need to be tailored to the development needs of each individual and their journey to step into a NED role on an NHS board;

- Arranging opportunities to learn from other board members and key staff, as appropriate.

6. Maximising the placement

6.1. Any programme should be customised to the development needs of each NExT Director (see above). This paragraph provides a list of ideas that will help the trust and the NExT Director get the most from the placement:
• NEtx Directors should take responsibility for their own learning and development by documenting experiences and learning outcomes, and identify areas the trust can help them develop further;

• Arrangements should be made to provide NEtx Directors with a full briefing on the NHS, the trust and its stakeholders – internal and external - as part of or soon after the induction programme;

• NEtx Directors should be encouraged to feel part of the team and invited to take part in board discussions, if this isn't possible then participating in committee debate may be more appropriate;

• Consider inviting NEtx Directors to participate in any organised programme of NED ward and / or site visits, or allocate a senior member of staff who could accompany them on such visits;

• Opportunities for the NEtx Director to shadow key senior staff should be offered, and meetings with representatives from staff and patient groups, HealthWatch, volunteers and hospital charities should be considered.

• Consider whether the NEtx Director should observe public board meetings of other trusts in the area to gain an insight into other leadership styles and approaches to governance as well as other types of providers;

• NEtx Directors will be strongly encouraged to network with and learn from other NEtx Directors. NHSI will be able to support them in this (see below).

7. Support from NHSI

7.1. All NEtx Directors will be invited to attend an NHSI induction event in September 2017. This will give them the opportunity to establish connections and networks with each other and will enable NHSI to provide an overview of working on a board and committees, and governance and accountability in the NHS.

7.2. Workshops, networking events and webinars will take place throughout the year, the agendas for which will be largely driven by the NEtx Directors and will give them exposure to subjects of wider interest both within and without the NHS. They will also provide an opportunity to reinforce connections between NEtx Directors and allow them to share experience and learn from each other.

7.3. Regular tracker conversations with providers and NEtx Directors will enable NHSI to track progress, quickly identify any potential issues and offer advice / guidance to ensure that the scheme provides the best possible experience and outcomes.

7.4. Access to the NEtx Director LinkedIn network, reading materials and regular updates from NHSI’s provider bulletin.

8. Moving towards the end of a placement

8.1. Placements with a trust can be for any period of up to twelve months, and NEtx Directors can opt to rotate to a placement on a different trust if this matches their
development needs. For example, an individual may wish to increase understanding of challenges faced by other service providers or exposure to different approaches to governance. If after six months it is felt that a NExT Director would benefit from such a move they and their current trust should contact NHSI to discuss options before the current arrangement comes to an end.

8.2. At the end of any placement, the trust should provide their NExT Directors with a structured appraisal, including an honest assessment of their progress and how close they are to being “board ready”. The NExT Directors should also be clear about any further development needs and be given guidance on how they might fill any gaps in their knowledge and experience going forward, particularly if the NExT Director is moving on to another placement.

8.3. At the end of the scheme, NHSI will offer NExT Directors additional support in applying for NHS NED roles in the future, including help preparing CVs and applications: independent panel assessment with a mock interview, summing up session, introductions to head-hunters, and scheme evaluation questionnaire.
Annex A

NExT DIRECTOR PLACEMENT AGREEMENT

This is important information about your placement as part of the NHS Improvement (NHSI) NExT Director Scheme. Please read it carefully and contact the NHSI Non-executive Appointments Team if you have any queries.

1. The NExT Director Scheme – provides you with an opportunity to gain first-hand experience of an NHS board through a placement with an NHS trust or NHS Foundation Trust. Although this will give you access to board and committee meetings, you will have no formal board role. This is not a public appointment or employment and does not entitle you to a position with the host Trust or any other Trust at the end of your placement.

2. Principles of public life - Public service values are at the heart of the NHS and Trust boards play a critical role in shaping and exemplifying an organisational culture that is open, accountable, compassionate, and puts patients first. Respect, compassion and care are at the centre of good leadership and governance in the NHS, and organisational and personal interests must never be allowed to outweigh the duty to be honest, open and truthful with patients and the public. You are therefore expected to:
   - understand and commit to the personal behaviours, values, technical competence and business practices outlined in “The standards for members of NHS boards and clinical commissioning group governing bodies in England” produced by the Professional Standards Authority;
   - reflect the standards of selflessness, integrity, objectivity, accountability, openness, honesty and leadership set out in the Seven Principles of Public Life;
   - uphold the policies and procedures adopted by the host Trust;
   - treat any information that is gained during the course of your placement with the Trust in the strictest confidence.

3. Time commitment – To get the most from your experience, you should attend all of the board, committee and other meetings you have agreed as with your mentor that you should attend as part of your development. You should confirm the time commitment you are able to give to the placement with your Trust, a minimum of two days a month, and whether you have the support of your employer (where appropriate).

4. Public speaking – You should not make political speeches or engage in other political activities relating to the work of the Trust during your placement.

5. Conflicts of interest – At the beginning of your placement you should declare to the Trust any business interests, position of authority in a charity or voluntary body in the field of health and social care, and any connection with bodies contracting for NHS services that may be relevant to the Trust.
6. **Visiting guidelines** - Visits to wards or other areas with access to patients must always be accompanied and planned beforehand, identifying where you are going and who you will speak to. Senior staff should be notified well in advance and always be clear about who you are and why you are there.

7. **Change in circumstances** - You should also notify the Trust and NHSI if there is any change to your situation or connections during the period of your placement. Any failure to do so could jeopardise the reputation of the Trust and / or NHSI and result in an end to your placement.

8. **Allowances** – Your Trust can reimburse you for reasonable and receipted travel and expenses incurred during your placement if necessary.

9. **Length of placement** – Your placement will last a minimum of six months. You may leave the scheme at any time by giving notice to your Trust and NHSI. Where possible, you should first speak with the chair of your host Trust.

10. **Ending your placement** - When your placement comes to an end, for whatever reason, you will immediately return any Trust property in your possession or under your control, and irretrievably delete or destroy any electronic or other information you hold that is relating to the business of the Trust and if requested, provide a signed statement that you have complied with this obligation.

I have read and understand the information above:

SIGNED…………………………………………………..   Date………………………..

PRINT NAME………………………………………………..
Title | Report from previous month’s Part 2 meeting
---|---
Author | Charlotte Hudson, Deputy Director of Corporate Governance
Accountable Director | Rachel Evans, Director of Corporate Affairs

**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 November 2017 when there was one issue for discussion.

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<th>Summary of discussion</th>
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<td>BOD PTII 44/17</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>
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Board of Directors Meeting
To be held 23rd January 2018
2:30 Learning Centre, Maudsley Hospital

AGENDA: Part 1

Opening Matters
1. Welcome, apologies for absence, declarations of interest 3:00pm
2. Minutes, Action log review
3. Patient Story - Kathryn 3:05pm
4. Chief Executive’s Report Rachel 3:15pm

Presentation
5. Black Thrive Matthew/Patrick Vernon

Strategy
6. SLAM Digital Strategy (MH recommendation on QI) Rachel/Stephen Docherty

Quality & Safety
7. Quality Improvement Update Michael
8. Public & Patient Involvement Update & External Relations Paper Beverley
9. Serious Incident Focus Beverley
10. CAMHS Report Anna/Charlotte
11. Physical Healthcare Beverley

Governance
12. Board Assurance Framework Beverley
14. Briefing from the Audit Committee December Meeting Steven Thomas
15. Council of Governors Update Rachel

Performance
16. Revalidation Michael
17. Finance Report & Q3 NHSI Report Gus
18. Performance Report Kris

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

The next Board of Directors Meeting will be held on 20th February 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.

web site: www.slam.nhs.uk