Board of Directors Meeting
To be held 18th September 2018
2:30pm - 5:00pm ORTUS, Maudsley Hospital

AGENDA: Part 1

Quality Improvement Focus
Presentation by teams about their QI Projects (located at the back of the room) 2:30pm

Opening Matters
136/18 Welcome, apologies for absence & declarations of interest & Conflicts of Interest Register 2:40pm Page 4
137/18 Minutes, Action log review 2:45pm Page 18
138/18 Patient/Carer Story Quality
139/18 CQC Inspection Update & Risk Focus: BAF Risk – 7 3:00pm Page 20
140/18 Q1 Lessons Learned 3:20pm Page 48
141/18 Q1 Learning from Deaths 3:30pm Page 63
142/18 Changing Lives – SLaM’s Strategy Refresh 3:40pm Page 69

Performance
143/18 Chief Executive’s Report 4:00pm Page 102
144/18 Council of Governors Update 4:05pm Page 105
145/18 Readout from NED/Governor Visit 4:10pm Verbal
146/18 Performance & Finance Report 4:20pm Page 107

Governance
147/18 Board Assurance Framework 4:35pm Page 151
148/18 Briefing from the FPC July Meeting Page 178
149/18 Briefing from the BDIC June & July Meeting Page 182
150/18 Briefing from the Quality July Committee Page 184

For Noting
151/18 Report from previous month’s Part II Page 187
152/18 Wrap-up and Proposed Next Meeting Agenda Page 188
153/18 Meeting Evaluation 4:50pm Verbal

The next Board of Directors Meeting will be held on 30th October 2018
2:30pm, at the ORTUS, Learning Centre, 82-96 Grove Lane, SE5 8SN.
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
<table>
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<tr>
<th>Name</th>
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<td>Dominy, Kristin</td>
<td>Chief Operating Officer</td>
<td>19/06/2018</td>
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<td>Member of Lambeth Living Well Network Alliance Board</td>
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<td>Chief Financial Officer</td>
<td>24/04/2018</td>
<td>✓</td>
<td>Pre April 2017</td>
<td>Ongoing</td>
<td>Wife works as an ad hoc contractor for various PR consultancies providing strategic PR advice to the pharmaceutical industry in respect of drugs and devices in various specialties.</td>
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<td>Medical Director</td>
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<td>✓</td>
<td>Jul-10</td>
<td>Ongoing</td>
<td>London School of Economics - Senior Fellow. Not involved in any actions that could involve this party.</td>
<td>£4,000</td>
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<td></td>
<td></td>
<td>22/01/2018</td>
<td>✓</td>
<td>Nov-14</td>
<td>Ongoing</td>
<td>Richmond Fellowship / Recovery Focus - Non-Exec. Not involved in any actions that could involve this party.</td>
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<td>Kara, Altaf</td>
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<td>✓</td>
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<td>Director of Nursing</td>
<td>24/04/2018</td>
<td>✓</td>
<td>Apr-18</td>
<td>Trustee of the Museum of the Mind</td>
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<td>24/04/2018</td>
<td>✓</td>
<td>Apr-18</td>
<td>Trusted of the Maudsley Charity</td>
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<td>Nothing to declare (IoPSN Executive Dean)</td>
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<td>✓</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Sep-17</td>
<td>Ongoing</td>
<td>External Advisor, Solicitors’ Regulation Authority</td>
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<td>Franklin, Mike</td>
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<td>✓</td>
<td>01/04/2018</td>
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<td></td>
<td>Independent member of Military of Defence Police Committee</td>
<td>c. £5k</td>
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<td>Hames, Duncan</td>
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<td>10/04/2018</td>
<td>✓</td>
<td></td>
<td>Pre-appointment Sep-17</td>
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<td></td>
<td>Ongoing</td>
<td>Owner Director of Human Dances Limited. This business had no dealings with the Trust or its associated organisations.</td>
<td>100% shareholding</td>
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<td>Mulroy, June</td>
<td>Non-Executive Director</td>
<td>24/04/2018</td>
<td>✓</td>
<td>2016</td>
<td>Ongoing Governance / NED, St Mary’s University College, Strawberry Hill, Twickenham</td>
<td>2014/15</td>
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<td>Trustee/Director, The Peel Institute (reg Charity)</td>
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<td>24/04/2018</td>
<td>✓</td>
<td>2013</td>
<td>Ongoing Director, Maudsley Charity</td>
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<td>24/04/2018</td>
<td>✓</td>
<td>Nov-17</td>
<td>Ongoing Broadacres Housing Association. Director / Shareholder. To be a Director is also necessary to be a shareholder (have one share)</td>
<td>£3,691.56 per annum</td>
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<td>Trustee, member of Audit Committee, Royal Voluntary Service</td>
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<td>24/04/2018</td>
<td>✓</td>
<td>Mar-18</td>
<td>Ongoing Trustee of Alpahma Charity, which funds third world and London-based social charities.</td>
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<td>24/04/2018</td>
<td>✓</td>
<td>Jan-15</td>
<td>Ongoing Vice Chair Kings Health Partners Academic Health Science Centre</td>
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Paffard, Roger Chair
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<th>As required by Standing Orders</th>
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<td>Strathdee, Geraldine</td>
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<td>01/01/2018</td>
<td>✓</td>
<td></td>
<td>Nov-13</td>
<td>Mar-18</td>
<td>Royal British Legion Poppy Factory Limited. Formerly a Board Trustee, now offering four pro bono targeted meetings a year to provide &quot;expert advice&quot; to promote the employment of mentally, physically disabled veterans at the Poppy Factory. Assist pro bono as a Patron.</td>
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<td></td>
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<td>15/05/2018</td>
<td>✓</td>
<td></td>
<td>Jan-18</td>
<td>Dec-18</td>
<td>National Professional Advisor, CQC. Discussed with Chair and CQC manager and identified that GS would discuss in 1:1 with both any necessary improvement actions.</td>
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<td>15/05/2018</td>
<td>✓</td>
<td></td>
<td>Mar-18</td>
<td>Jun-18</td>
<td>Improvement consultancy in GP Federation in multi-disciplinary teams design in Northern Ireland.</td>
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<td></td>
<td>15/05/2018</td>
<td>✓</td>
<td></td>
<td>Jan-17</td>
<td>Mar-19</td>
<td>Member of the RCPsych Informatics and Public Health Committee</td>
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<td></td>
<td></td>
<td>15/05/2018</td>
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<td>Jan-18</td>
<td>Mar-18</td>
<td>Advisor on policing and mental health for the national SIM programme and SLAM in a learning portal.</td>
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<td></td>
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<td>15/05/2018</td>
<td>✓</td>
<td></td>
<td>Jan-18</td>
<td>Dec-18</td>
<td>Pro bono policy and advocacy advice to Darzi review of NHS sustainable funding.</td>
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<td>15/05/2018</td>
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<td></td>
<td>Feb-18</td>
<td>Mar-19</td>
<td>Pro bono policy and advocacy advice to Rethink mental illness.</td>
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<td>15/05/2018</td>
<td>✓</td>
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<td>Jun-17</td>
<td>Dec-19</td>
<td>National Professional Advisor, CQC. Discussed with Chair and CQC manager.</td>
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<td>Chair, St George’s Hospital Charity; NED, St George’s Hospital Trading Limited.</td>
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<td>Dec-16</td>
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<td>Chair, Women in Rail Trading Community Interest Company (10510401) and Women in Rail (09859710)</td>
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<td>✓</td>
<td></td>
<td>Apr-13</td>
<td>Ongoing</td>
<td>Member and Vice Chair, Consumers’ Association (Welsh?), Due to end October 2019.</td>
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<td>Mar-11</td>
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<td>Director, Dwr Cymru Cyfyngedig (02366777); Director, Glas Cymru Holdings Cyfyngedig (09917809) (Welsh Water). Due to end 2020.</td>
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<td></td>
<td>Jul-05</td>
<td>May-17</td>
<td>Daughter was an employee of QCG, with whom the Trust has a contract.</td>
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<td>Mar-17</td>
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<td>Mar-17</td>
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<td>Member, Competition Appeal Tribunal. Due to end March 2026.</td>
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MINUTES OF THE HUNDRED AND TWENTIETH MEETING OF THE BOARD OF DIRECTORS OF THE SOUTH LONDON AND MAUDSLEY NHS FOUNDATION TRUST HELD ON 24 JULY 2018

PRESENT

Roger Paffard Chair
Béatrice Butsana-Sita Non-Executive Director
Rachel Evans Director of Corporate Affairs
Professor Ian Everall Non-Executive Director
Mike Franklin Non-Executive Director
Duncan Hames Non-Executive Director
Gus Heafield Chief Financial Officer
Dr Michael Holland Medical Director
June Mulroy Non-Executive Director
Beverley Murphy Director of Nursing
Dr Matthew Patrick Chief Executive
Sally Storey Interim HR Director
Dr Geraldine Strathdee Non-Executive Director
Anna Walker Non-Executive Director

IN ATTENDANCE

Temitope Ademosu Diversity Lead
Colan Ash Head of Risk and Assurance
Harold Bennison Director of Performance, Contracts and Operational Assurance
Jenny Cobley Lead Governor
Chithmini De Silva Engagement and Stakeholder Manager
Pauline Edwards Peer Recovery Trainer
Arleen Elson BME Network Chair
Kay Harwood Head of Planning and Strategy
Charlotte Hudson Deputy Director of Corporate Affairs
Brian Lumsden Deputy Lead Governor
Saim Kirhan Assistant Psychologist
Russell Mascarenhas NExT Director
Erica McAlpine Deputy Head of Communications and Media
Patience McLean Workforce Equalities Manager
Levis Mendonca Business Manager, MHPT
Matthew Neal Director of Estates and Facilities
Zoe Rafah Governor
Ros Ramsey Deputy Medical Director
Zoe Reed Director and Freedom to Speak up Guardian
Julie Stephens Strategy and Planning Manager
Sarah Thomas Director of Communications

APOLOGIES

Kristin Dominy Chief Operating Officer
Altaf Kara Director of Strategy and Commercial

BOD 114/18 WELCOME, APOLOGIES FOR ABSENCE, DECLARATIONS OF INTEREST

1
The Chair welcomed Béatrice Butsana-Sita to the Board as its newest Non-Executive Director.

**BOD 115/18 MINUTES, ACTION LOG REVIEW**

The minutes of the Board held on 19 June 2018 were agreed as an accurate record of the meeting and the Chair was content for the minutes to be regarded as signed by him on this date.

It was noted that the actions were all rated green.

**BOD 116/18 NURSE’S STORY**

It was noted that this slot was normally allocated to a serious incident or to a patient or carer story, but the Director of Nursing had asked Farida Pirani, a modern matron at the Ladywell Unit, to attend because she felt that her story would be of particular interest to the Board.

Farida explained that she had trained in Pakistan as a general nurse, and that this had been unusual for Pakistani women. In her third year, she had experienced a mental health setting where the provision was not well-developed and there was only one psychiatric ward for a range of issues. She was particularly interested in the approach to healing in shrines and how the approach could benefit people with mental health issues. Having completed a Masters qualification in the UK, Farida returned to Pakistan and persevered for a number of years to be able to pursue a career as a Registered Nurse Mental Health in the UK.

Farida discussed the treatment of a service user in one of our SLaM wards. The service user had sustained a head injury and had some elements of learning disability. He would tell members of staff that he could see Prophet Muhammed floating around and would talk to him. This made staff members nervous and fearful. Because of these concerns, he was not permitted to go on community leave to celebrate Eid with his family. No arrangements were put in place within the ward for him to celebrate Eid.

Farida engaged with the service user and started to understand that the messages relating to Prophet Muhammed were positive and comforting and that the service user was seeking to protect the people around him. With support, the service user was in a position to go to his family over Eid, some ten weeks later. His family had been overjoyed. He was later discharged.

Farida emphasised the importance of recognising that each person is unique and that they should always be treated with humanity.

Mike Franklin asked whether the ‘Prevent’ training would mean that some staff might have reported his behaviour. Farida explained that radicalisation is taken very seriously but that it was important to properly explore and understand his behaviour before labelling it. Every team she had worked with had taken radicalisation seriously.

Ian Everall asked how services can become better at being open to difference without being scared. He noted that the Equalities and Diversity training is not always sufficient to enable people to talk more easily about cultural issues or to help them become more culturally intelligent.
Geraldine Strathdee wondered whether the mental health legislation might hinder what is done in these circumstances because fear can lead to becoming unduly restrictive. There is a risk that one might choose not to explore what a service user might do when they are away from services, perhaps because there is not always the capacity to deal with the information.

Matthew Patrick wondered how best to retain and motivate talented people like Farida. Beverley Murphy stressed the importance of ensuring that nurses have a range of career options and expanding the range of opportunities that are available.

The Board thanked Farida for her openness, her honesty and her passion.

**BOD 117/18 RISK FOCUS – BAF RISK 13 – MANDATORY TRAINING**

Sally Storey presented this item, a deep dive into BAF risk 13: *If the Trust fails to meet its mandatory training compliance targets as a result of poor local management oversight, data quality or availability of courses, there is a risk to staff and patient safety and of breaching regulation of the local training gaps with a risk to the safety of staff and patients.*

She explained that improving compliance is a long haul, but following strenuous efforts over a sustained period the Trust has seen steady improvement and overall compliance has now reached our target of 85%. A wide range of controls are in place, and these have brought the initial assessment of the risk rating down. A gap in control and in assurance relating to the confidence in compliance data has been the subject of much effort across a number of teams and is close to being resolved.

The Trust has not always made it easy for staff or managers – data has not always been the most accurate for a variety of reasons, some training takes too long or is repeated too frequently, and these are all things which are being working on. Where there is a specific problem, such as shortages in capacity in terms of trainers or venues, they are addressed.

The Trust is still not where it needs to be in terms of compliance in all subjects, however, and some key subjects remain a challenge. These include life support, PSTS, and infection control, and specific action plans are in place which are already addressing each of these. The Director of Nursing is working with subject matter experts and will be reporting to the Senior Management Team on how requirements can best be streamlined.

The Chair noted that the paper was recommending a risk rating of 12, and asked how the focus on improvement would be maintained until the PSTS position improves. Sally Storey responded that training capacity had increased again following the loss of a venue and that there is a spike in training need because staff are no longer permitted to be exempt. It was anticipated that the rating would go to green within about a month.

Gus Heafield asked whether the next stage was a move towards competencies. Sally Storey explained that programmes are already mainly competency-based and that this was why many are face-to-face. Duncan Hames asked about the technology platform, it having previously been recognised that not all training had been captured. His sense was that the training had been clunky and not always reliable and wondered whether this got in the way of compliance. Sally Storey agreed that this had probably been part of the problem and that the team had sought
to improve the system. The team were not seeing the same volume of issues in terms of data reliability.

The Board congratulated the team on the progress made. More generally on the Board Assurance Framework, it was agreed that more information about the gaps in control should be included. Matthew Patrick also suggested that there was scope to revise the wording of the risks so that they read more clearly.

**BOD 118/18 SNOWY WHITE PEAKS / WORKFORCE RACE EQUALITY STANDARD: PREPARING FOR YEAR 2**

The team explained that they had conducted a review of progress against the Trust’s WRES ambitions after nine months. The paper highlighted some issues that needed further work.

The team talked the Board through one element of each of the four key strands of the strategy.

First, on Inclusive Leadership, the training had been overwhelmingly well-received with improvements having been self-reported in understanding at the end of the sessions and further work underway to ascertain whether it had resulted in a lasting positive impact. The provider would be surveying participants and their teams to better understand impact and the themes would be brought to the Equalities and Workforce Committee. The aspiration was to provide training to all managers, but it had proved difficult to pin down exactly how many people this covered. Recommendations on numbers for a further phase of sessions would be brought to the Senior Management team and the Equalities and Workforce Committee.

Secondly, the review and reflect checklist. This has not yet achieved its aim and this could be down to implementation issues. The Snowy White Peaks group would be working with the HR team and the Chief Operating Officer to ascertain if there were improvements needed to the form and the way that it is used.

Thirdly, on recruitment, there was a need to examine the ethnic breakdown of appointments by Directorate. The Board’s aspirations had been revised from looking only at Band 8a and upwards to looking at Band 7 and upwards. This is an ambitious target and would need focused work to demonstrate progress.

Finally, feedback on the new Diversity in Recruitment champions has been positive, with both the panel and the individual finding it helpful. An important issue to resolve was the use of interim opportunities so that they were made available in a transparent way and, where possible, as part of a development programme.

The Board noted that the Chair of the BME Network had organised a very successful and well-received meeting and talk with Yvonne Coghill, the Director of Workforce Race Equality Standard (WRES) Implementation at NHS England. Matthew Patrick noted that Yvonne Coghill had explained that these issues would take time to resolve but the Trust remains impatient to make improvements. She had also explained that it would be important for the whole Board to be engaged in this agenda. It was agreed that it would be helpful for Yvonne Coghill and her team to run a session with the Board.

Matthew Patrick highlighted that it was important that staff on temporary promotion should have an appropriate development package and support. Sally Storey agreed
that this was important but also stressed the need to be as transparent as possible about the opportunities in the first place.

Anna Walker recognised that the Board has three clear ambitions relating to the disparity of experience for BME staff and that progress had not been as great as had been hoped. She wondered whether the staff survey could provide some insight to the areas that needed work.

Mike Franklin wanted to give credit to the hard work that had been undertaken by the Snowy White Peaks Group. Whilst progress has not yet been delivered in all the areas that had been hoped for, there have been considerable strides in relation to some difficult issues that have been ongoing for a considerable time. The process will inevitably take time but it was important that the Board is firmly in support of the process; that the Chair and the Chief Executive had been highly visible in championing the improvements; and that commitments had been given to visit every team. He also highlighted the importance of capturing a broad range of BME views, not only those expressed by the network.

Gus Heafield asked about the impact for service users if the Trust gets better at this. It was noted that Yvonne Coghill had drawn clear links with the positive impact on quality of care and on staff satisfaction. She had also reported that Trusts that were making progress in this area had noted a positive impact across the board, including for white staff and patient groups.

The Chair concluded that the event with Yvonne Coghill had been compelling and that her offer to support the Board indicated that she felt a warm atmosphere in the room where the event was held. The Board was committed to making the most of the opportunity to work with her and make progress on this important agenda.

**BOD 119/18 IMPROVING STAFF SURVEY RETURN RATE**

The Trust's response rate was 44%, an improvement on last year's 40%, but still below the average for mental health trusts of 52%. The highest scoring mental health trust had a 68% response rate (Surrey and Borders). To dramatically improve SLaM's response rate, and ensure the survey is much more representative of all staff, HR has recommended a range of actions that have been supported by the Senior Management Team. These have been informed by learning from Trusts that get higher responses, and in essence include visible, energetic and committed leadership from the top, of the kind that has led to the improvements in our mandatory training results, ramping up the positive communications and getting out and about into work places introducing a level of competition and fun into it.

Béatrice Butsana-Sita queried why the response rate was so low. Completing the survey is an opportunity to provoke action by those who are unhappy. She noted that very long surveys could put people off completing them and wondered whether there is scope to reduce the number of questions. Sally Storey confirmed that sadly there was little scope to amend the form because it is in a standard format issued to all NHS trusts.

Ian Everall suggested speaking to the IoPPN about the progress they had made in this area. GS reflected on the ideas for encouraging returns and noted that completion was easier for those in corporate roles than those who work on the front line. She also suggested that the proposed rewards could be healthier, in line with the Physical Healthcare Strategy. Mike Franklin agreed.
Duncan Hames noted that 100 questions would take some time to complete. Sally Storey explained that staff were not expected to do this in their own time, although recognised the pressures of work.

Matthew Patrick felt that it was important to be ambitious about return rates and to push hard for improvements. He wanted the Trust to achieve a completion rate of 60% and to drive this with the enthusiasm and determination that had yielded such great improvements for flu vaccination.

**BOD 120/18 CENTRE FOR CHILDREN AND YOUNG PEOPLE (CYP)**

The paper was taken as read. The presenter highlighted that an additional 30 days was needed for the business case. Two different financial models were being deployed for price per square metre for the Centre for Young People and for Douglas Bennett House respectively and this needed to be resolved.

The proposals had been discussed at the Finance and Performance Committee. June Mulroy noted that there was still some financial modelling to do but it would be important for the Board today to provide acceptance in principle and to highlight any additional elements that should be looked at over the next 30 days.

A key element to bring out strongly in discussions on CYP is the importance to the services we provide. It was important to be clear that the centre was not an international centre for abstract future thinking and that it would deliver direct improvements to service users.

June Mulroy highlighted that the time delays involved in capital projects meant that these elements need early focus. There will then be a clear and robust focus on outcomes as the process moves to the service stage. Matthew Patrick reinforced this was the outline case for the building rather than the project as a whole.

The Board endorsed the direction of travel, was supportive of the ambition and supported the additional 30 days to resolve the financial issues. Any comments should be provided directly to June Mulroy or Gus Healfield.

**BOD 121/18 STRATEGY IMPLEMENTATION PROGRESS REPORT**

The paper was taken as read. The Chair highlighted that this was a staging post report to help ensure the right structure for the Board Away Day in September.

Geraldine Strathdee asked whether there was sufficient focus on the ‘brilliant basics’. The first Changing Lives ambition referred to a relentless focus on quality of care. Matthew Patrick explained that the strategy was, first and foremost, a Quality strategy. Each of the other elements flow from this central ambition.

Anna Walker supported an increased focus on the basics of quality care. She also felt that it was important to bring out the support to staff and the focus on co-production.

The Board noted that between the meeting and September, there would be a focus on the narrative. Matthew Patrick and others had been working with Helen Bradburn to simplify the story and ensure that the language resonated with staff and service users. The September Away Day sessions should also clarify the current context for NHS, mental health and social care to put work in context.
BOD 122/18 TRUST DATA FRAMEWORK DASHBOARD

The Board was talked through how the dashboard would work in action and how it could be accessed through Office 365. Martin Black highlighted that the Power BI team had done some excellent work and it had taken eight months from the initial stakeholder meeting. What was not yet known was how it would be used, who would use it and how often they would use it.

The next steps would be to gather feedback from individual Directorates and the Board. There would then be a programme of work to prioritise the work according to priority and resource. A soft-launch was planned for the end of July, with a view to increasing the number of people testing the system. During the soft launch, the functionality would be available to all staff but it would not be promoted until the new website was ready.

June Mulroy congratulated the team for the work. Access to consistent information would be a powerful driver for improvements. It would be useful to have a diagram setting out what data is covered, what the gaps are and what the timescales are for plugging the gaps. It would be important to close contradictory data sources so that people would be forced to use it.

Anna Walker commended the tool and, in particular, the data it provided for two of the Quality priorities. She noted that the BI team would be working with the Quality Committee to further develop the dashboard and the supporting data.

In response to questions from Matthew Patrick about ease of use, Martin Black explained that they would be reviewing the feedback with a view to making it as intuitive as possible for the novice user. The dashboard will be promoted through QI surgeries and other fora.

It was agreed, at Gus Heatfield’s suggestion, that a forward timetable with more detail would be useful. A detailed coaching session with the Board would be organised as soon as possible, with a view to ensuring that all Board members were confident accessing and engaging with the dashboard.

BOD 123/18 CHIEF EXECUTIVE’S REPORT

The paper was taken as read. The Chief Executive drew the Board’s attention to a brochure setting out the excellent achievements of the South London Mental Health and Community Partnership that had been distributed in hard copy at the Board.

BOD 124/18 FINANCE AND Q1 NHSI REPORT

The report was taken as read. Questions were raised by Geraldine Strathdee about the Lambeth overspill and whether or not this was regarded as predictable. It was explained that the differences between demand levels and discharge were not substantial but that they accumulated quickly.

The NHSI rating at page 58 of the pack was highlighted, because the Board needed to be sighted on the implications. The Trust was currently rated at a ‘3’, there having been a brief period when we had been a ‘1’. NHSI have been talked through the risks and the pressures. It is not anticipated that they will be concerned by the current position.
It was agreed that there should be an increase in the focus on agency, given that the current position is driven by the medical workforce. This will be monitored by the Finance and Performance Committee.

Russell Mascarenhas wanted to understand why the agency data is moving in the wrong direction, despite an improvement in the data for vacancies and sickness rates. Was it that the data was masking variation? Sally Storey confirmed that there were some hotspots of which the Trust is aware.

**BOD 125/18 PERFORMANCE REPORT**

The report was taken as read and had been taken through both the Quality Committee and the Finance and Performance Committee. On the NHSI indicators, there was a risk around the 7-day follow-up, but the June performance had turned a corner. The report contained data from the Community QuESTT dashboard. This meant that the 7-day follow-up data was more accessible for teams.

Duncan Hames questioned what was driving a marked and sustained increase in overspill, particularly given that the data on delayed discharges appeared to show a favourable position, recognising that the data only went to May. Harold Bennison explained that the numbers for Delayed Transfers of Care only record those delays that are formally agreed system delays. There are other barriers to discharge that are not captured. Duncan Hames reflected that he thought he was hearing that there is increased demand. Matthew Patrick confirmed that there had been a marginal increase in demand in Lambeth and Southwark but that the discharge rates had not changed. Ultimately, the issue came down to the balance between inflow and outflow.

The Chair noted that there needed to be an increased focus on length of stay and discharge and that it might be necessary to spend more time on this at the Board. Matthew Patrick confirmed that there would be a comprehensive intervention plan on this being brought to the September Board.

Anna Walker explained that the Quality Committee proposes to have a deep-dive into the IAPT pathway and to look at waiting times. The 7-day follow-up figures were also a new concern and it would be important to understand what was causing this.

**BOD 126/18 CAPITAL PLANNING, ESTATES AND FACILITIES DASHBOARD**

Matthew Neal introduced the report which had also gone the previous day to the Business Development and Investment Committee. The paper was treated as read but the following highlights were flagged.

Highlights included that the Strategic Outline Case for the Centre for Young Persons had been completed. There were some comments from the Finance and Performance Committee that would be incorporated into the document. Similar progress was made in relation to the Douglas Bennett House design. This was coming together in terms of cashflow and it was proposed to bring this to the Board in November with information about the costings.

There has been considerable work undertaken by the team in terms of reactive maintenance and addressing issues relating the CQC inspection. This had resulted in some other targets not being met. But the overall focus remains on compliance and this generally remains on track.
Lowlights included some issues with the capital programme. Three projects had issues and these were being worked on in partnership with the operational teams. It was clear from the capital plan that the Trust is slightly behind where it had wanted to be. The running costs were unlikely to be a true reflection of the position, but a more detailed picture would be able to be provided at the next meeting.

There were some risks relating to disposals of property. It was proving necessary to work with the Local Authorities in order to dispose as accommodation, even though this was not required from an NHS perspective.

Beverley Murphy highlighted that it could be seen as surprising that the Trust ended the last year behind plan on capital spend, given the concerning state of some of our estate. Matthew Neal felt confident that the picture would be more positive in November, with extra resources having been brought in to support programme management and design management with a view to accelerating progress.

June Mulroy wanted to express thanks to the estates teams on behalf of the Board for the responsive and collaborative working on the estates issues that were related to the CQC inspection. Duncan Hames supported this and Matthew Neal confirmed to him that the term “commercial uplift” referred to the project costing more than had been planned.

**BOD 127/18 REVALIDATION: ANNUAL REPORT**

Michael Holland highlighted that the focus going forward would be on improving the quality of appraisals. There was a need to align the systems with the IoPPN, because we were currently operating two separate systems. The numbers in relation to completed appraisals were high – at 95% last year and 96% this year.

Russell Mascarenhas asked about the ‘dip test’, which was only at 60%, and how best to strengthen the link with clinical governance.

Michael Holland noted that the feedback on the appraiser was good, but there seemed to be an appetite for more challenge. This would benefit from further reflection.

**BOD 128/18 COUNCIL OF GOVERNORS’ UPDATE**

The Lead Governor, Jenny Cobley, spoke on behalf of the Council of Governors.

She highlighted four points. First, that the Governors had welcomed the opportunity to visit the Ladywell site. The Governors feel strongly about the benefits of site visits. Secondly, there were concerns about the increase in demand. This would be discussed at an extraordinary Governors’ meeting. Thirdly, there continued to be progress with the lobbying and the possibility of Governors and local MPs joining together to ask that more money be put into mental health funding. This was discussed at the Governor meeting with the NEDs and would be explored further with the Chair. Finally, the Governors wanted to extend their sincere thanks to Harold Bennison for keeping them abreast of the latest information.

**BOD 129/18 BRIEFING FROM THE FINANCE AND PERFORMANCE COMMITTEE**

The Finance and Performance Committee meeting had taken place on the day before the Board. The Committee had recommended the approval of the signing for
the MRI scanner and the capital contribution to the Centre for Translational Informatics.

**BOD 130/18 BRIEFING FROM THE MENTAL HEALTH LAW COMMITTEE & NEW TERMS OF REFERENCE**

The Board were invited to ratify the new Terms of Reference. Geraldine Strathdee explained that the original terms were focused on ensuring compliance operationally with legal and regulatory standards. The new Terms of Reference now also included the need to apply the legislation in a way that fully recognised human rights, equalities, population health and the importance of data. It would be important to understand more about why people were being detained and whether the services were equitable and delivering the outcomes that people needed.

The Terms of Reference also delivered more granularity in terms of key elements of work, e.g. a workplan by September, and addressed the need to ensure that governance operated well on a local basis. There was a need to be more sighted on the quality of training and assessment of whether this led to rigorous implementation of the standards.

Geraldine Strathdee highlighted that the changed timescales in relation to s136 were creating difficulties for the Trust. There had previously been a period of 72 hours to find a suitable bed etc. but this had been reduced to 24 hours. The Trust was not currently able to consistently meet this shorter time limit. This meant that we were often in legal breach. A multi-agency event had been organised to help us. Mike Franklin asked how we compared to other Trusts in London and there was confirmation that other Trusts were encountering similar problems. Matthew Patrick suggested that the recent report on this should be circulated.

**Action:** The report on s136 delays in London should be circulated to Non-Executive Directors.

**BOD 131/18 FEEDBACK FROM THE NED / GOVERNOR VISIT TO THE LADYWELL UNIT**

Because of pressure of time, it was agreed that written feedback from this visit would be appended to the minutes of this Board meeting for information.

**BOD 132/18 UPDATED CEO AND SENIOR MANAGEMENT TEAM OBJECTIVES**

This document had been updated in light of comments at the previous meeting. The updated document was noted by the Board.

**BOD 133/18 REPORT FROM PREVIOUS MONTH’S PART II**

The Report was noted.

**BOD 134/18 WRAP UP AND NEXT MEETING**

The Board noted that the next meeting would take place in September.

**BOD 135/18 MEETING EVALUATION**

Both Ian Everall and Mike Franklin had been invited to evaluate the meeting. In terms of key outcomes, Ian Everall highlighted the improvements in mandatory
training compliance; the importance of the new dashboard; the 'in principle' approval of the CYP proposals; and the change to the Mental Health Law Committee terms of reference. He felt that the Board's input had added value, particularly in relation to training. There had been a good balance of issues, from the Snowy White Peaks discussion, to discussions on performance and the strategic narrative. A particular highlight had been the fascinating journey of the nurse from Pakistan. In terms of timing, the meeting had overrun but it was felt that the balance of issues had been appropriate. Mike Franklin agreed with Ian Everall's assessment and expressed the view that even where there was a heavy agenda, this did not mean that the time had not been used effectively.

The Chair thanked them both for their thorough and thoughtful evaluation.

The date of the next meeting will be:
18 September 2018, 14.30 – 17.00, ORTUS CENTRE

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
8th August 2018

Chair’s Office
Bethlem Royal Hospital
Monks Orchard Road
Beckenham
Kent, BR3 3BX
Direct Line: 020 3228-4763
Alison.Baker@slam.nhs.uk

Dear Donna and the Ladywell Team,

On behalf of all the NEDs and Governors who came to visit the Unit on 19 July, may I offer our thanks for such a well-organised, welcoming and informative morning. I appreciate that the arrangements had to be made at very short notice and we are very grateful that you all turned it around so quickly and professionally, especially during a period of particular and sustained pressure.

We left very impressed by the energy and drive and openness of the new team. We felt confident that you were clear where legacy issues were hampering a pursuit of best practice, and committed to driving out variability, raising standards, and sharing and celebrating best practice.

There were a number of things that struck us during the visit and which we have taken away to reflect upon and share with the Board. I shall summarise them here and invite you to let me know if there is anything we missed in terms of priorities or messages that you want the Board, or the Governors, to know or help with.

- These are relatively early days in the borough restructure, and many staff are new in post;
- The relaunch of Four Steps to Safety – recognising that previous attempts “fizzled out”, but is this time supported by Modern Matrons and QI methodology;
- Changing electronic platforms so as to better record physical healthcare and create a better fit with acute provider scoring;
- Recognition that the complexity of patients is increasing;
- Positive steps around accessibility of data through the performance dashboard, which is accessible to all staff and routinely monitored, and the flow of performance information from the ward up to PACMAN and Quality Compliance meetings;
- The desire to establish a Family & Carer group on site;
- The role of the Crisis Assessment Team in diverting people from A&E;
- Repeat crisis presentations from known patients and the desire to work with local agencies to stop that cycle;
• A focus on staff retention in an often-stressful environment;
• Challenges around discharge in light of rotas (e.g. no junior doctors on a Wednesday), consultant availability & rotas, community provision at weekends.
• A commitment to reducing length of stay to 30 days through focussing on discharge both on the ward and on the community flow. It was striking that an estimated 80% of inpatients are already known to our services;
• The reduction in violence and aggression on Virginia Woolf since it changed from a triage ward, but recognising the cultural change which did unsettle staff;
• The responsiveness of the SLaM Estates Team, although the challenges around the service agreement with Lewisham Hospital remain;
• The management team believe that the move to a borough structure – whilst not without its challenges in terms of implementation – will result in improvements in terms of multi-agency working, population health, sharing best practice, and driving out variability of standards across the wards, leading to enhanced consistency of care across the Unit.

I was particularly struck by your response to a Governor’s question about the drive to reduce length of stay and whether this has a negative impact on the quality of care. You said that, in your view, patient care is more likely to deteriorate because people are kept as inpatients for too long. Our Governors are very interested in readmission rates and whether they are linked to discharging patients too early, and so your view on that matter was an important contribution to that conversation.

It was also interesting to consider on-the-ground examples of the importance of partnership working. We often speak of delayed discharge owing to the lack of supported housing for our patients, but it was interesting to understand that this can be caused by a bottleneck further along the chain i.e. difficulties in moving people out of supported housing when they no longer need it.

We hope that you also found the visit useful. It is imperative that for “ward-to-board” flow of information, and escalation, to work effectively, the Board and the Governors must be sighted on the challenges (and the successes) in our services. We appreciated your candour and encourage you all to let us know when we can be of assistance, but also to not to be shy about your achievements.

Finally, another set of thanks to those staff who took the time to show us around the wards. One NED was particularly impressed with Johnson Ward, which she believed was the most organised and clean PICU she had ever seen, with an impressively visible range of information for patients. All visitors commented on the professionalism of the staff.

We had the pleasure of seeing Farida again on Tuesday 24th, at the Trust Board, where she gave a powerful and moving presentation, stressing the importance of personalised care plans and commitment to the needs of each and every service user. We look forward to seeing what she, and the rest of the Ladywell staff, achieve going forward.

Yours sincerely

Roger Paffard
Chair
Public Board meeting 24 July 2018 – 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>
<th>RAG</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Briefing from the Mental Health Law Committee</td>
<td>Report on s136 delays in London to be circulated to Non-Executive Directors.</td>
<td>Corporate Affairs</td>
<td>September 18</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Key:
- **Green** – completed
- **Amber** – on schedule
- **Red** – not on schedule
Title | Patient / Carer’s Story
---|---
Author | Parent Carer supported by Marianne Caitane, Patient and Public Involvement Facilitator, CAMHS Directorate
Presenter | Parent Carer, supported by Marianne Caitane

Purpose of the paper
Parent presentation about being a carer to her daughter who is also her carer and the issues and risks they face. To give an example of the complexities faced when the service user is also a carer for her mother and both their needs need to be considered during a crisis. The young person has now transitioned into adult services.

Risks / issues for escalation
BAF Risk 5 – Partnership working with service users - If the Trust fail to listen to the experience of people that use services and / or fail to implement the learning from all sources of adverse incidents there is a risk that services will not learn, not improve safety and present unacceptable risks for people that use services.

The Service User Story
My daughter was a service user in CAMHS and has now moved into adult services. I am a carer to my daughter, and my daughter is my carer.

How we got to CAMHS
- Referral to Faces in Focus for counselling by GP
- Then we were referred to CAMHS as we needed specialist treatment that only CAMHS could provide
- Overall experience at CAMHS has been positive
- As a parent, I’ve been involved in the decision-making, I’m always in the room and I’m given the choice to stay in the room
- My daughter also has a choice in whether I’m in the room

What makes my situation difficult?
An example of a difficult situation was when my daughter was in A&E during a mental health crisis
- She was assessed and had to wait in an interview room in A&E, as at that time she was too old to go to a paediatric ward and too young for an adult ward.
- We had to stay overnight, and I only had an uncomfortable chair to sit and my daughter on the two-seater sofa.
- I have a chronic physical health condition and had to make the difficult choice of going home, therefore leaving her in the hospital, or end up being admitted myself.
- I was naturally worried about my daughter staying alone without me in A&E, but also she was left with a male nurse and I was not comfortable with it.
- Thankfully my daughter told me the nurse was really nice
• The next day my daughter was reassessed, the A&E staff contacted CAMHS as soon as I mentioned she was a user of the service, and we saw our clinician the same day.

What help did I need?
• If there was a bed for me I would have stayed

What effect did it have on my child?
• She was anxious about me leaving her, especially as it was her first experience and she did not know what was going to happen

What we did not do well?
• That my health issues should be included in her care plan and clear actions indicated of what to do if I am in a crisis.
• Put things in place that help health and social care link up to support families
• A risk assessment that includes impact of both our health issues addressed in her care plan

What would you like to see?
• I would like support to be in place for my daughter to have health and social care professional help to make sure she is eating, taking her medication, bathing etc. These are the risks if I am unwell and not able to care for her.
• An awareness of how the risk to me is increased when stressed in a catch-22 situation and makes things worse.

What we have done well/ will do now/ what we are doing as a Trust? (identified by Marianne with Grace)
• We have listened. The Parent carer told her story of her experience at the Family and Carers’ Listening event in June 2018
• Katherine Allen, Lead for recovery and service user, carer and family experience, Birmingham and Solihull Mental Health NHS Foundation Trust gave a talk about ‘Planning for the future and Emergency Planning’ and the Trust is looking into creating information for families addressing this issue.
• CAMHS will discuss this issue and make recommendations for staff re considering more focussed care planning considering family’s needs and people caring responsibilities as family members. Resources: Think Family Strategy, new community care plan.
REPORT TO THE TRUST BOARD: PUBLIC
18 September 2018

<table>
<thead>
<tr>
<th>Title</th>
<th>CQC inspection July – August 2018 outcomes and response to regulation 29A warning notice &amp; Risk Focus: BAF Risk 7</th>
</tr>
</thead>
<tbody>
<tr>
<td>Author</td>
<td>Mary O'Donovan, Head of Quality</td>
</tr>
<tr>
<td>Accountable Director</td>
<td>Beverley Murphy, Director of Nursing</td>
</tr>
</tbody>
</table>

Purpose of the paper

1. To report the initial findings and outcome of the Core Service and Well Led inspections by the CQC in July – August 2018.
2. To note the key issues raised and the highlighted risks.
3. To share the updated corresponding BAF risk.
4. To outline the improvement work underway.
5. To outline the proposed governance of the improvement plan and the need to include the Quality Committee Chair and NED members in the approval of the improvement plans.

The Board is asked to approve the governance of the improvement plans and to agree the route of submission to the CQC.

Executive summary

This report outlines the following:

- Process of CQC Inspections 2018
- Early feedback (verbal) from the CQC
- Regulation 29A (HSCA) warning notice regarding the Acute and PICU pathway
- Immediate actions taken following warning notice
- Focus of improvement actions underway

Proposed governance structure developed to monitor improvement plan implementation

Risks / issues for escalation

**Quality Priorities**
Reducing violence, restraint, prone restraint and the use of Rapid Tranquilisation.

**Board Assurance Framework**

- BAF risk one- workforce
- BAF risk two- Operational delivery structure
- BAF risk seven- Quality and statutory compliance
CQC Inspection July–August 2018
Outcomes and Response to Regulation 29A Warning Notice

1.0 Introduction
As part of the Chief Inspector of Hospitals (CIH) inspection regime the Trust was subject to a planned comprehensive Care Quality Commission Well Led Inspection (CQC) during the months of July and August 2018. There were five service pathway lines inspected as part of this inspection process, table one outlines the most current ratings prior to the July 2018 inspection.

<table>
<thead>
<tr>
<th>Date - Month/Week</th>
<th>Inspection process</th>
</tr>
</thead>
<tbody>
<tr>
<td>20 March 2018</td>
<td>Notification of CQC inspection received by the Trust</td>
</tr>
<tr>
<td>12 April 2018</td>
<td>Provider Information return (data submission)</td>
</tr>
<tr>
<td>2- 4 July 2018</td>
<td>Inspection- Forensic Inpatient, Community MHOA, Crisis Services and Specialist Services</td>
</tr>
<tr>
<td>9-11 July 2018</td>
<td>Inspection- Acute pathway</td>
</tr>
<tr>
<td>16 July 2018</td>
<td>High level CQC verbal Feedback</td>
</tr>
<tr>
<td>25 July 2018</td>
<td>CQC Warning Notice (draft)- Acute and PICU Pathway</td>
</tr>
<tr>
<td>31 July 2018</td>
<td>Governors Focus group</td>
</tr>
<tr>
<td>08 August 2018</td>
<td>SLaM representation: Warning letter</td>
</tr>
</tbody>
</table>
13 August 2018  
CQC representation outcome- revised warning notice

14- 20 August  
Well Led inspection  
Focus Groups

Table two: CQC inspection timeframe/process March- August 2018

The initial information request asked for data/information outlined in table three below. The data/information ranged from simple factual answers to many dozens of subsets of data. The data was submitted on time although it was agreed with the CQC that the workforce data would need a longer timeline.

<table>
<thead>
<tr>
<th>PIR</th>
<th>Number of data requests</th>
</tr>
</thead>
</table>
| Mental Health specific | 12 data requests  
                        | 2 document requests |
| Universal            | 77 data requests  
                        | 45 document requests |

Table three: PIR data requests March/April 2018

Following the submission in April 2018 of the Provider (data) Information Return (PIR), there were further data requests (84) by the CQC from both clinical services and corporate services. The requests were made in the weeks leading up to the inspection and during the inspection. In addition, based on the verbal feedback that the CQC offered at the end of each day remedial actions were taken. The areas of focus for the actions are noted in table 3.

<table>
<thead>
<tr>
<th>Service Area</th>
<th>Number of Actions taken</th>
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<tbody>
<tr>
<td>Pharmacy/medicines</td>
<td>2</td>
</tr>
<tr>
<td>Corporate</td>
<td>4</td>
</tr>
<tr>
<td>Specialist</td>
<td>2</td>
</tr>
<tr>
<td>Crisis</td>
<td>4</td>
</tr>
<tr>
<td>Acute/PICU</td>
<td>28</td>
</tr>
<tr>
<td>Forensic</td>
<td>1</td>
</tr>
<tr>
<td>MHOA community</td>
<td>2</td>
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<tr>
<td>Total</td>
<td>43</td>
</tr>
</tbody>
</table>

Table Four: Actions taken by services during week of CQC inspection July 2018

The actions ranged from the substantial, for example moving a fence around an outdoor fire escape, to those that can be rapidly achieved such as ensuring fresh drinking water is always available for inpatients to help themselves to.
### 3.0 Verbal High Level Feedback

On the 16 July 2018, the Executive Board received high level verbal feedback about the cores inspection and on the 20th August 2018 about the Well Led inspection, summarised below.

<table>
<thead>
<tr>
<th>Feedback</th>
<th>Challenges</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>FORENSIC INPATIENT</strong></td>
<td>Staff on Norbury failed to escalate the drug fridge temperature despite noting it was too high.</td>
</tr>
<tr>
<td>- Improved since last inspected.</td>
<td>Not enough detail about individual episodes of restraint being captured.</td>
</tr>
<tr>
<td>- Significant reduction in violence and good use of restraint reduction measures.</td>
<td>Sharing of learning lessons from all kinds of incidents varied between wards.</td>
</tr>
<tr>
<td>- Good physical health care and care planning.</td>
<td>Effra ward had infrequent team meetings.</td>
</tr>
<tr>
<td>- Good easy read information.</td>
<td>Norbury ward was noted as being a stressful ward to work on.</td>
</tr>
<tr>
<td>- Strong team work.</td>
<td>Questions about the frequency of s132 rights being repeated – CQC considering further.</td>
</tr>
<tr>
<td>- Staff have freedom to innovate.</td>
<td>Issues with short staffing.</td>
</tr>
<tr>
<td>- Good psychology provision and restorative justice noted as positive.</td>
<td>Lack of clear action following audits.</td>
</tr>
<tr>
<td>- Good use of zoning.</td>
<td></td>
</tr>
<tr>
<td>- Can see work and efforts on food and good that self-catering is being considered however, the service users offered mixed feedback on the food itself.</td>
<td></td>
</tr>
</tbody>
</table>

| **EATING DISORDERS** | |
| --- | |
| - Improved in all of the challenged areas identified in the February 2018 inspection. | Documentation of restraint – although noted restraint is rarely used. |
| - Good use of clinical research to inform practice. | Lack of training and competency checks for new staff. |
| - Good that staff are trained to work with people with autism. | Insufficient social work and dietetic provision. |
| - The staff are all caring. | The lack of the ward manager post is thought to have an adverse impact. |
| - FREED has many positive aspects. | |

| **MHOA COMMUNITY** | |
| --- | |
| - Ability to access GP records for physical health care (L, S, L) is good. | Patients own medication being used / reused in HTT and a lack of a system to track use and returns of medication. |
| - Strong MDT working (Lam & Lew). | Insufficient mobile technology to enable clinicians to work effectively (L, S, L). |
| - Improved waiting times. | |
| - Good knowledge base and evidence base informing practice. | |
| - Positive service culture. | |
- Evidence of research informing practice.
- Positive impact of good senior leadership team.
- Decrease in the use of anti-psychotic medication in people with dementia.
- Good use of technology - Apps
- Detailed clinical assessments.
- Very caring staff.
- Working in schools to beat stigma and also the work to improve BME access.

<table>
<thead>
<tr>
<th>CRISIS SERVICES</th>
</tr>
</thead>
<tbody>
<tr>
<td>o Good risk management.</td>
</tr>
<tr>
<td>o Good use of zoning.</td>
</tr>
<tr>
<td>o Good use of psychology.</td>
</tr>
<tr>
<td>o Decrease in length of stay – HBPoS.</td>
</tr>
<tr>
<td>o Good safeguarding and physical health care.</td>
</tr>
<tr>
<td>o Personalised care planning.</td>
</tr>
<tr>
<td>o HBPoS – really good multi agency interface including working with police and AMHPs.</td>
</tr>
<tr>
<td>o Good that parents are able to stay with children.</td>
</tr>
<tr>
<td>o HBPoS – good environment.</td>
</tr>
<tr>
<td>o CAT – good initiative to divert people where service not required.</td>
</tr>
<tr>
<td>o Experienced managers and move to Boroughs is helpful.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>ACUTE and PICUS</th>
</tr>
</thead>
<tbody>
<tr>
<td>o Safeguarding was strong across the board.</td>
</tr>
<tr>
<td>o Impact of 4 steps to safety was seen as positive.</td>
</tr>
<tr>
<td>o Use of E-Obs seen as positive.</td>
</tr>
<tr>
<td>o Use of red to green days (JBU).</td>
</tr>
<tr>
<td>o Clare ward had addressed significant concerns following previous inspections.</td>
</tr>
<tr>
<td>o Positive use of NRT.</td>
</tr>
<tr>
<td>o Consistent approach to fire safety and fire safety audits.</td>
</tr>
<tr>
<td>o Supervision noted to be improving.</td>
</tr>
<tr>
<td>o ES2, JBU and Powell were noted to be 'excellent' wards.</td>
</tr>
</tbody>
</table>

| |
| Could obtain more feedback on the service from people with dementia. |
| Care plans could be more dementia friendly. |
| Learning lessons from all kinds of incidents was inconsistent as were team meetings. |
| Accessing physical health care information from Croydon GPs. |

| |
| Use of patients own medication and system for this. |
| CRHT splitting doses from pharmacy – needs review. |
| High use of bank (CRHT). |
| High caseload in Lambeth. |
| Insufficient supervision. |
| Capacity assessments not detailed enough or always there. |
| Patients’ rights poster in HBPoS incorrect. |

| |
| Recording or physical health care following rapid tranquilisation (RT) was a problem across all wards. |
| ES1 garden – fire escape from ES2. |
| Access to drinking water on Johnson ward. |
| Consistent control of environmental hazards (during the week 6 Ligature Anchor Points were identified not on assessment, there was 4 blind spots identified) and a lack of risk assessment in relation to the use of plastic bin liners. |
| Lack of progress with reducing prone restraint and the use of RT. |
Well led week

- High calibre Board.
- Chair and CEO ‘exceptional’ leaders.
- Exceptional partnership working – SLP and Alliances.
- Evidence of research being used in practice.
- Greatly improved relationship with Governors.
- Innovative use /development of technology.
- Some very good physical health practice, specifically the support offered to people to lead healthier lifestyles.
- Serious incident investigations go beyond requirements and are thoughtful.
- Care plans have improved.

Learning from incidents of all kinds was not in place, not facilitated by team meetings.

Access to beds and flow for patients is a significant issue.

A lack of discharge planning leading to timely and well-prepared discharges (although JBU and LK noted to stand out for positive practice). The trust was noted to be less proactive than other trusts with similar demands. Croydon noted to have specific difficulties.

Patients in the ARC awaiting the availability of a bed.

The attitude of AL2 staff was concerning and there was poor feedback from the patients about their care – expert by experience had concerns about quality.

Croydon PICU patients were not positive about the care they received.

Unwarranted variation across wards with increased concern about FM1, AL2, JD ward, Nelson ward, Virginia Wolf ward, TW1 & Croydon PICU.

Unwarranted variability in the quality of care.

Strategy is not fully formed; some staff are ‘vague’ about what it is / means.

Lack of clear offer to develop staff leadership abilities.

WRES action plan although initiatives and actions welcomed time and consistent effort is needed for it to have impact.

QI – a good start is evident however it needs to be spread across all parts of trust and needs embedding.

LGBT and lived experience networks need to grow.

Accessible Information standard needs to have impact in practice.

Patchy knowledge of Freedom to speak up
guardian role. The advocates would benefit from development and staff raised questions about the opportunities being advertised.

Staff side raised questions about having enough supported time to deliver against demands.

Supervision is patchy and inconsistent across the Trust.

Team meetings and the accountability for making them happen need to improve.

The improvement plan for EPPR needs to be delivered and embedded.

The Trust has a comparatively low number of peer support workers and the CQC hope to see us employ more.

Table five: CQC Verbal feedback

4.0 CQC Improvement Notice- Acute and PICU Pathway

On the 25 July 2018 the Trust received a draft Regulation 29A (HSCA) Warning notice for the Acute and PICU pathway. Following representations by the Trust the Warning Improvement notice was revised and re-issued on the 13 August 2018. The warning notice covered the areas below:

(i) The systems and processes you have in place to ensure you are compliant with the Health and Social Care Act 2008 are not operating effectively in the acute wards for adults of working age and the psychiatric intensive care units.

(ii) Sometimes you were not assessing and monitoring the quality and safety of the services you provide.

(iii) At other times you were assessing and monitoring, but then not taking the necessary steps to mitigate the risks to the health safety and welfare of patients using your services.

(iv) This meant that we found significant variation between wards over time that was impacting on the care and treatment received by patients.

The Trust has been asked to make improvements by the 1st April 2019. Many actions are already underway as a part of borough reorganisation and the recognition of these difficulties. Some new changes and improvement strategies have been implemented, and a broader improvement plan is being developed. The aim is to present the plan to the Board for approval following which it will be submitted to the CQC.

The corresponding BAF (BAF 7) has been reviewed and is attached at appendix 1 for consideration and approval.
4.1 Governance of our Improvement Plan

Following receipt of the Warning Improvement Notice the Trust Senior Management Team set about engaging with Trust Executive to develop a robust and achievable improvement plan.

These discussions resulted in the following priority areas for improvement:
(i) Fundamental standards of care
(ii) Governance
(iii) Leadership and culture
(iv) Clinical pathways including flow and discharge planning.

There is also a clear focus on ensuring that there is the right infrastructure in place (enablers) to support these improvements and a clear structure for engaging and communicating with staff (communication), service users and carers.

Six collaborative design workshops have been held with the Trust leadership to debate and agree the actions necessary to deliver the improvements needed. These have included input from Trust Service Directors, Clinical Directors, Heads of Nursing, professional heads and senior management teams. These ideas have been further tested by Trust leaders with local teams with a view to ensuring that they will deliver the necessary outcomes.

A clear governance structure for the improvement plan has been agreed which is outlined in the diagram below:

Organisational & Governance structures

![Organisational & Governance structures diagram](image-url)
On 23rd August 2018, the whole leadership team met to review the improvement plans and to identify co-dependencies and overlaps. The first Delivery Board was held on 28th August 2018 and recommendations were provided as to how to further improve the plans and ensure robust measurement. The principles of the delivery board are outlined in the Delivery Board terms of reference a summary of which are outlined below and also in appendix 2, attached.

The principle purpose of the Delivery Board is as set out below:

- Oversee the development and implementation of improvement plans based on, (but not limited to), the outputs of the CQC visit
- Ensure that the work streams are delivered and evidenced across the organisation and not limited to the acute and crisis care pathway
- Scrutinise evidence and provide assurance that improvements are embedded as part of business as usual across the organisation
- Manage oversight of any budgets / contingencies that may arise as part of these plans
- Manage risk identification, mitigation, oversight and scrutiny
- Oversee key project deliverables
- Keep the project to time – March 2018 target
- Recommend closure of actions to the Portfolio Board following assessment of evidence that organisational embedding is robust

The teams are now developing the detail of the plans together with the operational directorate implementation plans in preparation for internal submission on 7th September. The plans, once considered by the Delivery Board and approved by the Quality Portfolio Board will be submitted to the Board of Directors for ratification. They will also be discussed with our Governors. Consideration needs to be given about the role of the Quality Committee Chair and NED membership in this process.

The principle purpose of the Our Improvement Plan Quality Portfolio Board is:
Strategic Oversight: Implementation and Delivery of Our Improvement Plan

a) Ensuring alignment of Our Improvement Plan with the vision, values and culture of clinical governance, quality, patient safety and clinical standards across the organisation
b) Promoting clinical leadership and engagement in the development and delivery of Our Improvement Plan
c) Reviewing and ensure that lessons from delivery of Our Improvement Plan are learned and implemented across the organisation
d) Receiving reports from the Trust Management Board and, where relevant, ensure implementation of recommendations via Our Improvement Plan work streams. These recommendations could result from:
   - Quality Committee recommendations
   - Internal reports
   - External reports
   - Clinical audit reports
   - Clinical accreditation visits
   - Service reviews
   - Legislation, regulations and guidance which address clinical governance, quality, patient safety and clinical standards

e) Supporting Quality Board in the delivery of its work programme with a specific remit on providing assurance to the Quality Board on delivery of Our Improvement Plan

Risk management and internal control

a) Management of risks related to delivery of Our Improvement Plan are escalated as appropriate to the Board Assurance Framework and Corporate Risk Register and to take lead responsibility for identified risks
b) Receiving reports and assurance from the Delivery Board in respect of Our Improvement Plan risks and ensuring mitigating actions are both robust and implemented at pace
c) Assessing any other risks related to delivery of Our Improvement Plan brought to the attention of the Board

Finance

a) Where a matter relating to quality or performance has a significant financial implication the Our Improvement Plan Quality Portfolio Board will refer that matter to the Finance and Performance Committee, and/or refer to the Trust Board where appropriate
b) Scrutinise the cost improvement schemes to ensure achievement of the annual plan
c) Review and approved recovery cost improvement plans where necessary in support of achieving the annual plan.

The draft terms of reference are at Appendix 3.

The principle purpose of Oversight and Scrutiny is:

- Our Improvement Plan is designed to address effectively the feedback and outputs of the CQC inspection (appended). This includes ensuring that work streams are appropriately scoped, have clarity on objectives, are evidence based, make use of relevant standards (that will be made available to OSGIP as needed) and improvement interventions clarify desired outcomes and have robust work plans
• Whilst the focus of OSGIP is SLaM's improvement plan for the work of our acute wards and how this extends into relevant community teams, some recommendations will have broader relevance for the organisation (such as in leadership and culture) and to that extent OSGIP will look at recommendations that may have wider application. However, OSGIP will not seek to provide advice or scrutiny on issues that do not directly affect the acute pathway or the scope of Our Improvement Plan.
• Improvements are embedded as part of business as usual across the organisation, but our plans will be phased to ensure targeted prioritisation of the services most in need, and with clarity about where immediate, short, medium and longer term action is needed and the outcomes we will achieve in the next 6, 12 and 18 months
• The OSGIP will work in a spirit of constructive challenges, focussing on identifying where there is excellence, and optimising the cross organisational assets, staff engagement and shared learning
• Changes in risks within our BAF and corporate risk registers are identified and logged appropriately and that mitigation action is appropriately taken
• Our Improvement Plan’s implementation plans and execution give confidence of on-time delivery – March 2019 as the first target and the subsequent 12, 18 and 24 months
• Our Improvement Plan is governed effectively to ensure transparency, effective surfing and resolution of issues, performance management, interdependencies are managed and communication is effective.

The draft terms of reference are at Appendix 4.

4.2 Improvement Underway

The initial feedback given by the CQC was recognised by the trust leadership, we had already identified a problem. The reorganisation of the delivery arm of the Trust into Operational Directorates was specifically designed to address many of the issues raised. Service Directors, working with Clinical Directors and Operational Directorates now have an area of responsibility that significantly improves local leadership and oversight. The inspection occurred within weeks of the transition being made hence why the actions of the leadership had not yet made an impact with creating consistency in the quality of care.

The work the leadership team commenced at the point of change included assessing the risks in each of the operational directorates and ensuring that teams had the support to make change with the leadership team ensuring oversight and positive outcomes. The local leadership teams are using the outcome of the inspection to target their interventions, for example, in Lambeth the leadership team members have each ‘adopted’ a ward to attend team meetings to support good use of data and debates about the quality of care. In the CAG structure this approach to local leadership was not possible due to the geographical spread of services impacting relationships.

4.3 Immediate Actions Taken

In parallel with designing plans that will accelerate the delivery of sustainable long-term improvements, the Trust has also taken a number of immediate actions to tackle areas of concern. These include:

4.3.1 Targeted Action at Borough Level

The new borough leaders have been engaging directly with teams in the acute pathway to drive immediate improvements to standards in the areas identified in the notice. These will report regularly to the Delivery Board.
4.3.2 Post Rapid Tranquilisation Physical Health Care Monitoring
Have developed a co-produced training module for roll out across all inpatient units. The training sets out clear requirements in relation to post-rapid tranquilisation, together with Quality Improvement methodology to support each team to understand how to achieve consistent standards.

4.3.3 E-observations
The e-obs tool is now fully deployed in the Ladywell unit and will be rolled-out to all in-patient teams at the Maudsley and Lambeth Hospitals by the end of September. E-obs is important because it supports real time oversight of physical health care observations including post rapid-tranquilisation.

4.3.4 Risks to Quality – using data effectively
The Senior Management Team are now routinely looking at a data set that tracks from floor to Board areas that are potential risks to quality. These are considered at a weekly Safety huddle every Wednesday morning where data relating, for example, to post-rapid tranquilisation physical health care follow-up and people detained on a section 136 that lapses before a suitable outcome is identified are scrutinised and debated.

4.3.5 Care pathway, flow and discharge
The Trust is the first mental health trust to implement MADE events (multi agency discharge events) and a number have already been held to address the delays to flow across services. Initially two MADE (multi agency discharge events) events will be held per Borough, supplemented by a trust wide workshop to improve the work between ED liaison and home treatment teams (17/9) and a comprehensive set of winter pressures bids with an indication of support from our local commissioners which we have already drafted.

4.3.6 Engaging our Staff on the Improvements
Events are planned for each Borough in September to talk staff, leaders, stakeholders and service users about the improvements that are planned and how they can contribute. Trust is also creating a designated intranet site for staff to access information about the planned improvements and how they can access support. Maud – the redesigned trust intranet – will also be going live offering improved communication and information to staff across the Trust.

4.3.7 ES1 garden – risk of fall from height
The environmental improvements to remove this risk are now complete.

4.3.8 Staff Networks
The LGBT and LEN networks will be attending the Senior Management Team to discuss the package of support they need in order to enable these new networks to flourish.

4.3.9 Trust Strategy – Changing lives
The Board is receiving the final version of the refreshed strategy narrative at the September Board, following which there will be a programme of engagement and consultation. This will include a set of consultation events with service users, carers and their families and other community partners and
stakeholders that will proceed from the Autumn and which will result in additional, supporting and personalised expressions of the strategy which will also be used in communication going forwards.

5.00 Approving our Improvement Plan

The improvement plan has been constructed over a series of meetings with the trust leadership team, it has been through two Delivery Boards and by the time of the Board happening will have been further revised and been considered.

Once the plans are ready for the Board approval they will be submitted for consideration. We have advised the CQC of our Board on the 18th September, the plan will only be submitted once the delivery, quality and scrutiny functions are satisfied that is it correct.

6.0 Conclusion

The Trust is still awaiting the outcome of the inspection, until the reports are received and checked for accuracy the feedback must be considered as subject to change. Only when the reports are received can we be confident about the ratings however on the balance of the feedback to date and the warning notice we can expect a deterioration in the rating for acute and PICU and improvement in the other pathways inspected.

Whilst receipt of a warning notice for the Acute and PICU pathway is very disappointing, the Trust considers the warning notice as an opportunity to provide maximum impetus to the improvement ambitions which the Trust has been working on for some time already. The move to Operational Directorates in the weeks preceding the inspection is designed to create local leadership, narrowing the scope for managers and improving the impact and outcome of local actions. Whilst it is unfortunate that the inspection took place during the period of transition we are confident that this local leadership is a key opportunity in improving the quality of care and the oversight of risks to quality.

It is the aim of the Trust to evidence and demonstrate what we have delivered significant further change within the period of the warning notice, focusing on improving outcomes for patients and staff. Some of the improvements will be able to be delivered quickly and we are pressing ahead with these at pace. However, we also recognise that for change to be sustained, some improvements will take longer to achieve and longer still to embed. This work will extend beyond the life of the warning notice. We want our improvement plans to be delivered in three six-month phases so that we can prioritise the actions that will have the greatest impact, monitor outcomes and deliver maximum engagement.

Mary O’ Donovan
Head of Quality
29 August 2018

Appendix 1: BAF risk 7

Appendix 2: Draft terms of reference Delivery Board

Appendix 3: Draft terms of reference Quality Portfolio Board

Appendix 4: Draft terms of reference Overview and Scrutiny Group
### Appendix 1

#### Principal Risk 7 (Quality & statutory compliance)
In the context of significant demand, change and unpredictable clinical situations and following the initial feedback from the CQC from the July 2018 inspection there is a potential risk that the trust will fail to deliver the necessary regulatory actions (Must do's and regulation 29A warning notice) and quality improvements identified by the CQC or meet our other regulatory duties and therefore create a risk of breaching regulation and/or statutory duties.

<table>
<thead>
<tr>
<th>Owner:</th>
<th>BM / DoN</th>
</tr>
</thead>
<tbody>
<tr>
<td>Committee:</td>
<td>Quality committee</td>
</tr>
<tr>
<td>Proximity:</td>
<td>12 months</td>
</tr>
<tr>
<td>Risk Category:</td>
<td>Quality (patient safety, experience &amp; clinical outcomes)</td>
</tr>
<tr>
<td>Risk Appetite:</td>
<td>Cautious (nominal range 3-8)</td>
</tr>
<tr>
<td>Potential Causes (links to the CRR)</td>
<td></td>
</tr>
</tbody>
</table>

The context of consistent delivery of mental health services across four London Boroughs; significant need and deprivation; a time of unprecedented NHS financial challenge; current levels of funding is amongst the lowest in the country; the transformation of services creates significant pressure for people leading services and people delivering services. This challenges the capacity and capability of an organisation to make change and improvements.

| Key Controls | |

Internal: Established, well led Board of Directors, experienced Service and Clinical Directors, clear operational and professional structure, quality governance, operational performance management, recruitment of sufficient high quality staff. Good knowledge or regulatory standards. CQC PID, action plan and core planning meeting in place. Monthly Operational Directorate Quality Governance Compliance meeting embedded. Risk management strategy and incident reporting structure in place. Established health safety and fire management procedures and governance arrangements. Ligature anchor point audit and management procedures and annual risk reduction programme. CQC preparation meetings. Borough Directors (fresh set of eyes) full site visits. SMT quality visits (to all sites within the year). Significant mitigations in place to address issues accessing beds (MADE etc).

External: established relationships with commissioners, full engagement with alliance boards, engagement / leadership of transformation programmes (locally and nationally). CQRG clinical quality review group chaired by CCG

| Sources of Assurance | |

COO Quality report, Learning lessons reports, compliance reports, CQUINN reports, progress reports of delivery of CQC inspection improvement actions, QUEST scores, safer staffing reviews, QI progress reports, reported progress on delivery of strategy, monthly quality compliance committees with Operational Directorates embedded and Quality matters governance meetings embedded.

| Gaps in Control | |

Short of staff in some areas (e.g. CPNs). Governance framework and outcome measures agreed as part of Alliance development but not yet fully tested in practice. Not all Boroughs have recruited a full senior management team. Southwark Head of Nursing not yet recruited. Inconsistent completion of physical healthcare checks following rapid tranquillisation. Inconsistent implementation of standards of care & quality governance across Acute pathway. Bottlenecks, obstacles & lack of agreed processes/protocols and clarity on pathway, flow and discharge management. Gaps in governance leading to problems with 'floor to Board' oversight of risks.

| Gaps in Assurance | |

QI methodology is starting to build however the approach is new and will take time to embed. Data Quality, compatibility & integrated report issues being addressed by data summit. Transition of quality governance information into a format reflecting the new borough structures not yet completed. Evidence of failures in local governance arrangements to ensure incidents/reports are escalated appropriately (e.g. ward report of beds not being available for patients returning from leave or CTOs not being appropriately escalated).
Appendix 2

‘Our Improvement Plan’
Delivery Board
Terms of Reference (ToR)

1. Authority and function
The Delivery Board does not have executive power. It reports to the monthly Quality Portfolio Board, which in turn reports to the Trust Board. It will periodically report to other Board level committees as required or directed by the Board.

It is empowered to monitor, challenge and direct the delivery of improvement plans as part of the Improving Quality programme informed by the July and August 2018 CQC inspection.

The Delivery Board has a key role in identifying and mitigating risks to delivery of the improvement plans and has the responsibility to escalate to the Portfolio Board or to the CEO directly areas of concern.

2. Project Board Objectives
The Board aims to support operational delivery of a number of projects that are both already in train and that have arisen from the July – August 2018 CQC inspection. The Board will oversee the development and implementation of plans to address issues raised, and make recommendations as to which projects should be delivered.

The principle purpose of the Board is as set out below;

- Oversee the development and implementation of improvement plans based on, (but not limited to), the outputs of the CQC visit
- Ensure that the work streams are delivered and evidenced across the organisation and not limited to the acute and crisis care pathway
- Scrutinise evidence and provide assurance that improvements are embedded as part of business as usual across the organisation
- Manage oversight of any budgets / contingencies that may arise as part of these plans
- Manage risk identification, mitigation, oversight and scrutiny
- Oversee key project deliverables
- Keep the project to time – March 2018 target
- Recommend closure of actions to the Portfolio Board following assessment of evidence that organisational embedding is robust

Document history:

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<td>21/08/18</td>
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<td>Redrafting</td>
<td>SMT</td>
<td>22/08/18</td>
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<td>Beverley Murphy</td>
<td>Redrafting</td>
<td>SMT members</td>
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3. **Membership**

The membership and responsibilities are as set out below:

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<thead>
<tr>
<th>Name</th>
<th>Project Board Role</th>
<th>Responsibilities</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Leadership</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Beverley Murphy</td>
<td>Chair of Delivery Board (SRO)</td>
<td>To lead the Board and provide strategic direction</td>
</tr>
<tr>
<td>Kris Dominy</td>
<td>Vice Chair of Delivery Board</td>
<td>Support leadership of the Board &amp; the strategic direction</td>
</tr>
<tr>
<td>Michael Holland</td>
<td>Vice Chair of Delivery Board</td>
<td>Support leadership of the Board &amp; the strategic direction</td>
</tr>
<tr>
<td>Rachel Evans</td>
<td>Assistant Chair Delivery Board</td>
<td>To manage the links to Board Assurance Framework</td>
</tr>
<tr>
<td><strong>Improvement Plan Design Leads</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Neil Robertson</td>
<td>Leadership and Culture</td>
<td>Design of Improvement Plan</td>
</tr>
<tr>
<td>Donna Hayward Sussex</td>
<td>Pathway, Flow and Discharge Management</td>
<td>Design of Improvement Plan</td>
</tr>
<tr>
<td>Vanessa Smith and Dan Harwood</td>
<td>Fundamental Standards of Care</td>
<td>Design of Improvement Plan</td>
</tr>
<tr>
<td>Jo Kent</td>
<td>Governance</td>
<td>Design of Improvement Plan</td>
</tr>
<tr>
<td>Altaf Kara</td>
<td>Key Enablers</td>
<td>Design of Improvement Plan</td>
</tr>
<tr>
<td>Sarah Thomas</td>
<td>Communication</td>
<td>Design of Improvement Plan</td>
</tr>
<tr>
<td><strong>Operational Delivery</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Jo Kent</td>
<td>Implementation lead</td>
<td>Southwark Operational delivery of work-streams</td>
</tr>
<tr>
<td>Donna Hayward- Sussex</td>
<td>Implementation lead</td>
<td>Lewisham Operational delivery of work-streams</td>
</tr>
<tr>
<td>Neil Robertson</td>
<td>Implementation lead</td>
<td>Lambeth Operational delivery of work-streams</td>
</tr>
<tr>
<td>Faisal Sethi</td>
<td>Implementation lead</td>
<td>Croydon Operational delivery of work-streams</td>
</tr>
<tr>
<td>Sarah Thomas</td>
<td>Implementation lead</td>
<td>Specialist communications advice and delivery of communications work stream</td>
</tr>
<tr>
<td>Stephen Docherty</td>
<td>Implementation lead</td>
<td>Key enabler - IMT</td>
</tr>
<tr>
<td>Matthew Neal</td>
<td>Implementation lead</td>
<td>Key enabler – E&amp;F</td>
</tr>
<tr>
<td>Harold Bennison</td>
<td>Implementation lead</td>
<td>Key enabler - BI</td>
</tr>
<tr>
<td><strong>Oversight and Scrutiny</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Gus Heatfield</td>
<td>Corporate Assurance</td>
<td>Oversight and Scrutiny</td>
</tr>
<tr>
<td>Altaf Kara</td>
<td>Corporate Assurance</td>
<td>Oversight and Scrutiny</td>
</tr>
<tr>
<td>Colan Ash</td>
<td>Corporate Assurance</td>
<td>Oversight and Scrutiny</td>
</tr>
<tr>
<td><strong>Support Team</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Rod Booth</td>
<td>Assurance, reporting and supporting Implementation Leads. Deputy Chair of Board</td>
<td>To provide operational assurance, governance and reporting</td>
</tr>
<tr>
<td>PMO support</td>
<td>Secretariat support</td>
<td>Administration, action tracking for board.</td>
</tr>
</tbody>
</table>

*Additional support will be requested as required*
4. **Quorum**
To be quorate, the chair, or one vice chair must be present with at least two other members.

5. **Frequency of meetings**
The board will be every two weeks, usually in advance of the Portfolio Board. An extraordinary launch programme is set out below to initiate the programme.

Papers will be submitted one week in advance to the PMO, who will provide secretariat support to this board.

Actions are to be completed before the meetings they are due and an update provided to the secretariat support.

6. **Meeting Governance**
The board is empowered to make operational decisions to keep the programmes on track for quality, cost, time, and scope. The board will make recommendations for budgets where necessary and will manage budgets that are approved at the Quality Portfolio Board.

The quorate team will escalate issues where appropriate based on changes to quality, cost and time that are outside of approved limits of either SFIs, SOs, or those set at the Trust Board.

The chair will provide updates to the Quality Portfolio board and to the CEO as necessary, and is responsible for escalation and two-way communication of decisions.

Decisions made at this board will be made in agreement of the quorate panel; the chair will cast a deciding vote in the event of a stalemate.

Actions and key decisions will be recorded by the PMO secretariat support. These will be stored within Microsoft Teams.

7. **Review**
The ToRs are in draft until approved at the Quality Portfolio Board 13th September and ratified by the Board of Directors 18th September 2018. They should be reviewed annually.

Any significant changes in scope or membership will require them to be re-written and approved at a subsequent board.
Appendix 3

‘Our Improvement Plan’
Quality Portfolio Board

Terms of Reference (ToR)
V2

Document history:

<table>
<thead>
<tr>
<th>Author(s)</th>
<th>Changes</th>
<th>Circulation</th>
<th>Date</th>
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<tr>
<td>PMO</td>
<td>Initial draft</td>
<td>Beverley Murphy, Rod Booth</td>
<td>03/09/2018</td>
</tr>
<tr>
<td>Rod Booth</td>
<td>Updates to reflect revised governance structure and Quality Board Relationship</td>
<td>Beverley Murphy</td>
<td>08/09/2018</td>
</tr>
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</table>

1. **Authority**

The Improvement Plan Quality Portfolio Board is authorised by the Board of Directors:

a) To investigate any activity within its terms of reference and produce an annual work program
b) To approve or ratify (as appropriate) those improvement plans for which it has responsibility
c) To promote a learning organisation and culture, which is open and transparent
d) To establish and approve the terms of reference of such sub-committees, groups or task and finish groups as it believes are necessary to fulfil its terms of reference
e) Support the Quality Board in the delivery of its work programme with a specific remit on providing assurance to the Quality Board on delivery of Our Improvement Plan

The Improvement plan quality portfolio board can commit financial resources in respect of matters identified in these terms of reference and as set out in the Scheme of Delegation and Standing Financial Instructions (SFIs). The Director of Finance must be informed of any decision requiring use of resources. Any other matters requiring a decision on the use of resources are to be referred to the Trust Board and/or the Director of Finance, and/or following the appropriate investment pathway.

The Board of Directors approved the establishment of the Improvement Plan Quality Portfolio Board to:

a) Provide a focus on improving the quality and safety of patient centred healthcare in accordance with the Trust objectives
b) Provide a focus on clinical governance, quality and patient safety and operational performance issues in relation to the improvement plans
c) Provide detailed scrutiny of Our Improvements Plan; to provide assurance and raise concerns (if appropriate) to the Board of Directors
d) Make recommendations, as appropriate, on the delivery of Our Improvement Plan matters to the Board of Directors
e) Assess and identify risks within the quality portfolio and escalating as appropriate
The Improvement Plan Quality Portfolio Board is accountable to the Board of Directors and any changes to these terms of reference must be approved by the Board of Directors.

The work programme of Improvement Plan Quality Portfolio Board will be informed by outputs from Delivery Board which have been subject to critical friend challenge by the Overview and Scrutiny Group of Our Improvement Plan (OSGIP).

**Overview and Scrutiny Group Dependencies**

OSGIPs primary function is to provide challenge and oversight to the improvement plan arising from the CQC inspection acting equally as a critical friend to the executive team and as an assurance mechanism to the Board.

OSGIP’s scope and focus is on Our Improvement Plan, encompassing the work of our acute wards and how they extend into relevant community teams. Clearly there will be implications for the whole Trust in addressing these issues (e.g. in leadership etc.), but these recommendations will eventually move into implementation when they will be assured through the normal working of the Quality Committee.

In its role as an assurance mechanism to the Board, OSGIP will act as a defined sub-group of the Quality Committee that is dedicated to this task, invited by the Chair of the Quality Committee to present views at the Board on a monthly basis and empowered to engage all committee chairs, including of the Quality Committee and Audit Committee, in contributing to the work on how our governance should evolve.

In that respect, Overview and Scrutiny would be formally under the umbrella of the Quality Committee but with a standing invitation via the Chair of the Quality Committee to provide Board Assurance. This arrangement would recognise current arrangements for managing quality assurance and the fact that Overview and Scrutiny has a limited existence whilst also recognising that the essential role Quality Committee plays and the packed nature of its agenda for business as usual.

2. **Quality Portfolio Board Objectives**

   **Strategic Oversight:**
   **Implementation and Delivery of Our Improvement Plan**

   f) Ensure alignment of Our Improvement Plan with the vision, values and culture of clinical governance, quality, patient safety and clinical standards across the organisation

   g) Promote clinical leadership and engagement in the development and delivery of Our Improvement Plan

   h) Review and ensure that lessons from delivery of Our Improvement Plan are learned and implemented across the organisation

   i) Supporting Quality Board in the delivery of its work programme with a specific remit on providing assurance to the Quality Board on delivery of Our Improvement Plan

   j) Receive reports from the Trust Management Board and, where relevant, ensure implementation of recommendations via Our Improvement Plan work streams. These recommendations could result from:

   - Quality Committee recommendations
   - internal reports,
   - external reports,
clinical audit reports
clinical accreditation visits
service reviews
legislation, regulations and guidance which address clinical governance, quality, patient safety and clinical standards

Risk management and internal control

d) Management of risks related to delivery of Our Improvement Plan are escalated as appropriate to the Board Assurance Framework and Corporate Risk Register and to take lead responsibility for identified risks

e) Receiving reports and assurance from the Delivery Board in respect of Our Improvement Plan risks and ensuring mitigating actions are both robust and implemented at pace

f) Assessing any other risks related to delivery of Our Improvement Plan brought to the attention of the Board

Finance

d) Where a matter relating to quality or performance has a significant financial implication the Board will refer that matter to the Finance and Performance Committee, and/or refer to the Trust Board where appropriate

e) Scrutinise the cost improvement schemes to ensure achievement of the annual plan

f) Review and approved recovery cost improvement plans where necessary in support of achieving the annual plan.

3. Membership

The Quality Portfolio Board will include the following members:

a) Chief Executive Officer (Chair)
b) Medical Director
c) Director of Nursing (Deputy chair)
d) Chief Operating Officer
e) Director of Governance

All members listed above have voting rights.

The Chair of the Quality Portfolio Board is the Chief Executive Officer. The Deputy Chair of the Quality Portfolio Board is the Director of Nursing. If the Chair is not present, then the Deputy Chair shall chair the meeting.

<table>
<thead>
<tr>
<th>Name</th>
<th>Role</th>
<th>Responsibilities</th>
</tr>
</thead>
<tbody>
<tr>
<td>Matthew Patrick</td>
<td>Chair</td>
<td>To lead the Board and provide strategic direction</td>
</tr>
<tr>
<td>Beverley Murphy</td>
<td>Deputy Chair</td>
<td>Support leadership of the Board &amp; the strategic direction</td>
</tr>
<tr>
<td>Kris Dominy</td>
<td>Member</td>
<td>Support leadership of the Board &amp; the strategic direction</td>
</tr>
<tr>
<td>Michael Holland</td>
<td>Member</td>
<td>Support leadership of the Board &amp; the strategic direction</td>
</tr>
</tbody>
</table>
### 4. Quorum

A quorum will be three members, of whom there should be:

- a) At least one should be the chair or deputy chair
- b) At least one should be an Executive Director
- c) Where financial matters are considered, the director of finance or chief financial officer must be present

### 5. Frequency of meetings

Meetings will normally take place monthly and at least two weeks before a Board of Directors meeting.

Papers will be submitted one week in advance to the PMO, who will provide secretariat support to this board.

The business of each meeting will be transacted within a maximum of two and a half hours.

### 6. Meeting governance

Members of the board have a responsibility to:

- a) Attend at least 80% of meetings, having read all papers beforehand
- b) Act as ‘champions’, disseminating information and good practice as appropriate
- c) Identify agenda items, for consideration by the Chair, to the Lead Director /Secretary at least 5 days before the meeting
- d) Prepare and submit papers for a meeting, at least 5 clear working days before the meeting
- e) If unable to attend, send their apologies to the Chair and Secretary prior to the meeting and, if appropriate, seek the approval of the Chair to send a deputy to attend on their behalf
- f) When matters are discussed in confidence at the meeting, to maintain such confidences
- g) Decisions made at this board will be made in agreement of the quorate panel; the chair will cast a deciding vote in the event of a stalemate
- h) Actions and key decisions will be recorded by the PMO secretariat support
6. Programme Organisational Structure

8. Review
Terms of Reference will normally be reviewed annually, with recommendations on changes submitted to the board for approval.

Any significant changes in scope or membership will require them to be re-written and approved at a subsequent board.
Appendix 4

‘Our Improvement Plan’

Overview and Scrutiny Group

Draft Terms of Reference (ToR)

Document history:

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<th>Author(s)</th>
<th>Changes</th>
<th>Circulation</th>
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<tr>
<td>Altaf Kara</td>
<td>Initial draft</td>
<td>OCSIP</td>
<td>30/08/18</td>
</tr>
<tr>
<td>Geraldine Strathdee</td>
<td>Comments to initial draft</td>
<td>OSCIP</td>
<td>30/08/18</td>
</tr>
<tr>
<td>Roger Paffard</td>
<td>Comments to initial draft</td>
<td>OSCIP, Quality Committee Chair, BDIC Chair</td>
<td>31/08/18</td>
</tr>
<tr>
<td>Matthew Patrick</td>
<td>Comments to initial draft</td>
<td>OSCIP and Quality Committee Chair</td>
<td>04/09/18</td>
</tr>
<tr>
<td>Altaf Kara</td>
<td>Final draft</td>
<td>OSGIP and Quality Committee Chair</td>
<td>05/09/18</td>
</tr>
</tbody>
</table>
1. Authority and Function
The Overview and Scrutiny Group of Our Improvement Plan’s (OSGIP’s) primary function is to provide challenge and oversight to the improvement plan arising from the CQC inspection acting equally as a critical friend to the executive team and as an assurance mechanism to the Board. OSGIP is not a decision making body.

It will have a limited period of existence – broadly linked to when implementation of findings has started which is approximately 8 months from now. Any extension beyond this period will need to be agreed by the Chair of the Trust, the Chair of the Quality Committee and the Chair of Overview and Scrutiny Group.

OSGIP’s scope and focus is on Our Improvement Plan, encompassing the work of our acute wards and how they extend into relevant community teams. Clearly there will be implications for the whole Trust in addressing these issues (e.g. in leadership etc.), but these recommendations will eventually move into implementation when they will be assured through the normal working of the Quality Committee.

The critical friend role would be played by providing feedback to the CEO and the Director of Nursing which they would use in the Quality Portfolio Board and Delivery Board which they chair respectively.

In its role as an assurance mechanism to the Board, OSGIP will act as a defined sub-group of the Quality Committee that is dedicated to this task, invited by the Chair of the Quality Committee to present views at the Board on a monthly basis and empowered to engage all committee chairs, including of the Quality Committee and Audit Committee, in contributing to the work on how our governance should evolve.

In that respect, Overview and Scrutiny would be formally under the umbrella of the Quality Committee but with a standing invitation via the Chair of the Quality Committee to provide Board Assurance. This arrangement would recognise current arrangements for managing quality assurance and the fact that Overview and Scrutiny has a limited existence whilst also recognising that the essential role Quality Committee plays and the packed nature of its agenda for business as usual.

OSGIP will meet monthly and receive a monthly report compiled by the executive members of the OSGIP after the Delivery Board in the month and before the Quality Portfolio Board in the month. Members will be empowered to visit or join any part of the programme at any time.

Members of OSGIP have an open invitation to attend the Quality Portfolio Board, the Delivery Board and any other meetings they wish to go to in order to fulfil their role.
2. OSGIP Objectives

The Overview and Scrutiny Group of Our Improvement Plan (OSGIP) aims to provide assurance on the appropriate and effective functioning of Our Improvement Plan. This covers a number of projects that are both already in train and that have arisen from the July – August 2018 CQC inspection and related issues flowing from the July 2018 CQC Insight information flow, and feedback from our CQC Trust relationship manager.

The Director of Nursing would continue to act as lead relationship manager with CQC and may wish to involve the chair of OSGIP or the Quality Committee in fulfilling that role. OSGIP will be provided with all relevant data flows from CQC and Mental Health Act inspections in relation to Our Improvement Plan.

The principle purpose of OSGIP is to assure the Board that:

- Our Improvement Plan is designed to address effectively the feedback and outputs of the CQC inspection (appended). This includes ensuring that work streams are appropriately scoped, have clarity on objectives, are evidence based, make use of relevant standards (that will be made available to OSGIP as needed) and improvement interventions clarify desired outcomes and have robust work plans.
- Whilst the focus of OSGIP is SLaM’s improvement plan for the work of our acute wards and how this extends into relevant community teams, some recommendations will have broader relevance for the organisation (such as in leadership and culture) and to that extent OSGIP will look at recommendations that may have wider application. However, OSGIP will not seek to provide advice or scrutiny on issues that do not directly affect the acute pathway or the scope of Our Improvement Plan.
- Improvements are embedded as part of business as usual across the organisation, but our plans will be phased to ensure targeted prioritisation of the services most in need, and with clarity about where immediate, short, medium and longer term action is needed and the outcomes we will achieve in the next 6, 12 and 18 months.
- The OSGIP will work in a spirit of constructive challenges, focussing on identifying where there is excellence, and optimising the cross organisational assets, staff engagement and shared learning.
- Changes in risks within our BAF and corporate risk registers are identified and logged appropriately and that mitigation action is appropriately taken.
- Our Improvement Plan’s implementation plans and execution give confidence of on-time delivery – March 2019 as the first target and the subsequent 12, 18 and 24 months.
- Our Improvement Plan is governed effectively to ensure transparency, effective surfacing and resolution of issues, performance management, interdependencies are managed and communication is effective.
3. **Membership**

The membership and responsibilities are as set out below;

<table>
<thead>
<tr>
<th>Name</th>
<th>OSGIP Role</th>
<th>Responsibilities</th>
</tr>
</thead>
<tbody>
<tr>
<td>Geraldine Strathdee</td>
<td>Chair (NED)</td>
<td>To chair the committee, ensure thorough examination and challenge progress and governance of Our Improvement Plan and provide feedback on committee findings to the board.</td>
</tr>
<tr>
<td>Roger Paffard</td>
<td>Vice Chair (NED)</td>
<td>To support the chair, examine and challenge progress and governance of Our Improvement Plan.</td>
</tr>
<tr>
<td>Duncan Hames</td>
<td>Member (NED)</td>
<td>Examine and challenge progress and governance of Our Improvement Plan.</td>
</tr>
<tr>
<td>Matthew Patrick</td>
<td>Member</td>
<td>To support the chair, examine and challenge progress and governance of Our Improvement Plan and use feedback for interrogation in Quality Portfolio Board.</td>
</tr>
<tr>
<td>Altaf Kara</td>
<td>Member</td>
<td>To summarise delivery progress for OSCIP, examine and challenge progress and governance of Our Improvement Plan.</td>
</tr>
<tr>
<td>Gus Heafield</td>
<td>Member</td>
<td>To summarise delivery progress for OSCIP, examine and challenge progress and governance of Our Improvement Plan.</td>
</tr>
<tr>
<td>Colan Ash</td>
<td>Member</td>
<td>Examine and challenge progress and governance of Our Improvement Plan with a particular focus on risk.</td>
</tr>
<tr>
<td>Beverley Murphy</td>
<td>Chair, Delivery Board</td>
<td>Presenting progress and detail on Our Improvement Plan</td>
</tr>
<tr>
<td>Rod Booth</td>
<td>PMO lead</td>
<td>Acting in a PMO capacity</td>
</tr>
</tbody>
</table>

*Additional support will be requested as required*

4. **Quorum**

To be quorate, the chair, or vice chair must be present with at least two other members, one of whom must be Gus or Altaf.
5. Frequency of Meetings

OSGIP will meet every month, in advance of the Quality Portfolio Board and after the Delivery Board.

Papers will be submitted one week in advance to the PMO, who will provide secretariat support to OSGIP.

Actions are to be completed before the meetings they are due and an update provided to PMO.

6. Meeting Governance

The OSGIP will use a range of methods to ensure the objectivity and effectiveness of its Oversight. In addition to receiving regular reports before monthly meetings, it will, where it is considered necessary, seek a range of floor to board validations, including seeking specific quantitative information reports, occasional attendance at meetings, and through floor visits to meet patients and staff, and scrutinise records and care plans.

OSGIP will provide feedback to the CEO (as Chair of the Quality Portfolio Board) and DoN (as Chair of the Delivery Board) in its role as critical friend. In providing Board Assurance it will be invited by the Chair of the Quality Committee to present views at the Board on a monthly basis escalating significant risks to the achievement of the objectives of Our Improvement Plan. It will be empowered to engage all committee chairs, including of the Quality Committee and Audit Committee, in contributing to work already underway on how our governance should evolve in light of the CQC inspection.

Actions and key decisions will be recorded by the PMO secretariat support. These will be stored within Microsoft Teams.
7. Organisation Structure

8. Review
The ToRs are in draft until approved by the Board of Directors on 18 September 2018. They should be reviewed annually.

Any significant changes in scope or membership will require them to be re-written and approved at a subsequent board.
REPORT TO THE TRUST BOARD: PUBLIC
18 September 2018

<table>
<thead>
<tr>
<th>Title</th>
<th>Lessons Learned report – Quarter 1</th>
</tr>
</thead>
</table>
| Author | Edith Adejobi, Head of Complaints  
Lucy Stubbings, Head of Patient Safety |
| Accountable Director | Beverley Murphy, Director of Nursing |

Purpose of the paper

This is a regular report to the Board which sets out:

1. The Q1 Lessons Learned report provides details of the activity and key lessons arising from incidents, complaints, PALS, claims, Central Alerting System (CAS alerts) and inquests.
2. The Board is asked to note this report and decide whether any further action or briefing is required.

Executive summary

The quarterly lessons learned report provides the Board with a quarterly update on adverse incidents, which includes summary information about some of the themes of learning and performance data.

Key lessons in quarter 1 were identified through an independent review completed by Dr Jane Carthey, Human Factors and Patient Safety Consultant who identified 16 cross cutting themes across the Trust and 6 themes identified in each of the CAGs (now operational directorates). It is proposed that Dr Carthey will deliver workshops within the Trust to each Directorate to enhance the learning on these themes.

Two preventing future death reports were received and responded to within the quarter, highlighting additional learning for CAMHS in relation to communication with young people and their families around care planning and crisis support. A second report led to actions being taken in relation to observation and engagement; review of the policy, audit of standards and a blue light bulletin reminding staff of their responsibilities. Observation and engagement was identified in several incidents where there was inconsistent recording of observations. The actions identified will be reviewed through a SNAP audit to assess compliance with standards.

Data is provided for incidents (3313), complaints (127), inquests (12), claims (19), CAS alerts (36), quality alerts (17) and PALS contacts (797) received in Q1 with analysis of this data.

Key Recommendations from the report

- Report to be made available to all services via Directorate governance meetings and through the intranet.
- Learning to be triangulated with quality improvement initiatives to identify gaps in learning.
- Delivery of cross cutting themes workshops based on independent review findings with Directorates to improve learning

The Board is asked to:

- Note the content of the report
- Make additional recommendations as required
**Risks / issues for escalation**

This report relates to the BAF risks

BAF Risk 5 – Partnership working with service users - If the Trust fail to listen to the experience of people that use services and / or fail to implement the learning from all sources of adverse incidents there is a risk that services will not learn, not improve safety and present unacceptable risks for people that use services.

BAF Risk 7 – Quality & statutory compliance - In the context of significant demand, change and unpredictable clinical situations there is a potential risk that the trust will fail to deliver the necessary regulatory actions (must do's) and quality improvements identified by the CQC or meet our other regulatory duties and therefore create a risk of breaching regulation and/or statutory duties.

**Committees where this item has been considered**

<table>
<thead>
<tr>
<th>Date</th>
<th>Committee / Meeting</th>
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<tbody>
<tr>
<td>11 Sep 2018</td>
<td>Quality Committee</td>
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1. Introduction

The Trust’s Board receives a quarterly update on adverse incidents, which includes summary information about some of the themes of learning and performance data. The report will also be received by the CQRG.

The Q1 Lessons Learned report provides details of the activity and key lessons arising from incidents, complaints, PALS, claims, Central Alerting System (CAS alerts) and inquests. During Q1 the Trust transitioned to Directorates, the data in this report is based on the most recent directorate structures, there may be some changes to these once the Datix system is updated.

2. Lessons Learned

2.1 Blue Light Bulletins

One Blue light bulletin was published in quarter 1 highlighting patient safety learning from across the Trust.

Search Awareness for all inpatient teams

A serious incident investigation highlighted the need to improve awareness of the Trust’s policy regarding searching of hospital premises, service users and their property to provide clarity around the level of searching when high and immediate risks are identified. The bulletin highlighted the relevant legislation as well as local guidance, training and available support

2.2 Learning from Incidents investigations concluding in Q1

There were 19 serious incident investigations submitted to commissioners in Q1. The investigations made recommendations leading to 86 actions which were recorded onto Datix.

<table>
<thead>
<tr>
<th>CAG</th>
<th>Number of reports submitted</th>
<th>Number of actions</th>
</tr>
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<tbody>
<tr>
<td>BDP</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>CAMHS</td>
<td>1</td>
<td>*</td>
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<tr>
<td>Croydon</td>
<td>6</td>
<td>16</td>
</tr>
<tr>
<td>Lambeth</td>
<td>1</td>
<td>4</td>
</tr>
<tr>
<td>Lewisham</td>
<td>4</td>
<td>8</td>
</tr>
<tr>
<td>Psychological Medicine &amp; Older Adults</td>
<td>2</td>
<td>6</td>
</tr>
<tr>
<td>Southwark</td>
<td>4</td>
<td>6</td>
</tr>
<tr>
<td>Total</td>
<td>19</td>
<td>42</td>
</tr>
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</table>

* Not complete at time of report

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<tr>
<th>CAG</th>
<th>CAG-Wide</th>
<th>Local</th>
<th>Trust wide</th>
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<tbody>
<tr>
<td>BDP</td>
<td>1</td>
<td>1</td>
<td>0</td>
</tr>
<tr>
<td>Croydon</td>
<td>5</td>
<td>8</td>
<td>3</td>
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<tr>
<td>Lambeth</td>
<td>0</td>
<td>1</td>
<td>3</td>
</tr>
<tr>
<td>Lewisham</td>
<td>6</td>
<td>2</td>
<td>0</td>
</tr>
<tr>
<td>Psychological Medicine &amp; Older Adults</td>
<td>6</td>
<td>0</td>
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</tr>
<tr>
<td>Southwark</td>
<td>1</td>
<td>4</td>
<td>1</td>
</tr>
<tr>
<td>Total</td>
<td>19</td>
<td>16</td>
<td>7</td>
</tr>
</tbody>
</table>
Each action is themed using the Datix action module, the following themes were identified in the quarter

### Table 3 Actions by theme

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<thead>
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<th>Number of actions</th>
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<tbody>
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<td>Communication with patients</td>
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</tr>
<tr>
<td>Competency/ training</td>
<td>5</td>
</tr>
<tr>
<td>CPA (care pathway approach)</td>
<td>1</td>
</tr>
<tr>
<td>Efficiency</td>
<td>4</td>
</tr>
<tr>
<td>Environment - hazards</td>
<td>2</td>
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<tr>
<td>Environment - security</td>
<td>1</td>
</tr>
<tr>
<td>Local protocol/procedures</td>
<td>4</td>
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<tr>
<td>Other</td>
<td>4</td>
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<tr>
<td>Risk assessments</td>
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<tr>
<td>Trust policy</td>
<td>5</td>
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<tr>
<td><strong>Total</strong></td>
<td><strong>42</strong></td>
</tr>
</tbody>
</table>

2.3 **Key Learning points identified from recommendations from complaints, incidents and inquests concluding in Q1**

**2.3.1 Complaint, PALS and incidents learning**

A number of complaints investigations identified learning related to communication with patients; including when appointment delays occur or with telephone communication. In one instance a care coordinator unable to attend an appointment due to inclement weather did not inform the service user and when contacted sent a discourteous response; while in another complaint an administrator was found to have been rude to a service user calling to follow up an appointment. As a result of these complaints staff received clearer guidance to better support upset or distressed patients during telephone calls, with targeted supervision and training to reinforce service awareness of expected standards of patient communication.

Another investigation identified multiple issues where disappointing communication was compounded by poor attitude and behaviour. The actions to take forward learning included changes to care planning, individualised care plans monitored by monthly audits and improved supervision to underline the importance of proactive and on-going communication.

**2.3.2 Learning from inquests**

The Trust received 2 Preventing Future Death reports during Q1. In the case of the suicide of a young person under CAMHS, Miss Y, the issues raised by the Coroner were:

a) **Failing to communicate in writing a care plan and changes to it**

b) **Failing to provide a clear route or opportunity to challenge or appeal these changes to the care plan**

c) **Falling to communicate in writing all routes to raise concerns on a non-emergency or emergency basis**

In the case of the death of an older adult inpatient, the issues raised by the Coroner were:

a) Inaccuracies in the recording of observations and cotemporaneous entries made to the record without reference and the impact of this on patient safety

8 actions were identified by the PMOA Directorate and Director of Nursing including a Blue Light Bulletin on observations – completed on 06/07/2018, learning conversations, revised observation and engagement policy and learning lessons training for registered nurses. Monitoring on the observation and engagement standards will be completed through SNAP audits.
2.3.3 Learning from Comprehensive Investigations completed Q1

Croydon Directorate – Probable suicide of an AWOL inpatient (July 2017)
Two key learning points were identified from the investigation
- Completion of reliable observations would have identified that the patient was absent from the ward earlier
- The execution of the section 135(2) warrant would have reduced delays in returning the patient to the ward

Southwark Directorate – Probable suicide of a patient on leave (June 2017)
Two learning points were identified from the investigation
- Risk assessments were not completed – the audit system on the ward has been updated in line with the Trust’s requirement
- Consideration of training for personality disorders on the ward

2.3.4 External review of learning from Serious Incidents Requiring Investigation (SIRI)

An independent review of themes from SIRIs was commissioned by the Trust from Dr Jane Carthey, Human Factors and Patient Safety Consultant, to identify themes and enhance learning across the Trust through the development of vignettes for teaching sessions.

16 cross cutting themes were identified including with 6 of these identified in all CAGs (now operational directorates).
1. The care plan was superficial or incomplete: Risks or triggers specific to a patient had not been properly documented.
2. Transfers across teams where the care plan, treatment plan or risk assessment has not been updated to reflect the new environment or by the new team, or where this information has not been clearly communicated across teams.
3. Off the radar: Patients for whom the team loses situational awareness of the patient; either because risk information is distributed across multiple different teams, or there is lack of recognition and timely action when the patient starts to disengage with services.
4. Recording of information on EJPS: information either not recorded under the correct tabs or assumptions were made that because risk or care plan information was on EJPS it did not need to be communicated or handed over.
5. Gaps in service provision: Where current structures and/or lack of resources in a team or teams contributed to omissions in care.
6. Referral and admissions pathways that are not followed or where the referral requirements are unclear.

For each of the 16 cross cutting themes vignettes have been compiled from the Trust’s serious incident investigations. Dr Carthey will deliver workshops in conjunction with the Director of Quality Governance/Deputy Director of Nursing and Patient Safety Team to allow each Directorate to reflect on the learning and its applicability in their clinical area. These workshops will be open to all staff in the Directorate/site, governors and NEDs.

3. Reported data in Q1

3.1. Incident data

Reported incidents inform Trust strategy, highlight areas of risk and are used to improve patient safety. Q1 saw 3,313 incidents reported in comparison to compared to 3,079 in Q4. The numbers of reported incidents, as outlined in chart 1, remain unremarkable.
Incidents are categorised by the reporter and reviewed and validated by the approver, who is ordinarily the team leader for the reporting service. Once approved the incident will be uploaded to the National Reporting and Learning Service (NRLS) and included as part of published data if a patient safety incident. Data on incident type is reviewed at Directorate level and selected data is reported to specific committees e.g. Reducing restrictive interventions committee reviews violence/aggression/assault data and prone restraint data with learning from each of the Directorate highlight reports.

In line with previous quarters, during Q1 the types of incidents reported most frequently across the range of severities were:

1. Violence/Aggression/Assault (1180) – slight increase from 1096 in Q4
2. Clinical Care which includes practice relating to the management of patients with substance misuse and pressure ulcers (487) – slight increase from 461 in Q4

### Table 4 Types of incident reported in Q1

<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>Violence/aggression/assault</td>
<td>1</td>
<td>8</td>
<td>290</td>
<td>589</td>
<td>292</td>
<td>1180</td>
</tr>
<tr>
<td>AWOL/abscond/failed to return</td>
<td>0</td>
<td>2</td>
<td>87</td>
<td>134</td>
<td>22</td>
<td>245</td>
</tr>
<tr>
<td>Clinical care (inc. substance misuse/pressure ulcer/wound)</td>
<td>0</td>
<td>5</td>
<td>129</td>
<td>155</td>
<td>198</td>
<td>487</td>
</tr>
<tr>
<td>Medication</td>
<td>0</td>
<td>0</td>
<td>111</td>
<td>44</td>
<td>35</td>
<td>190</td>
</tr>
<tr>
<td>Self-harm</td>
<td>0</td>
<td>11</td>
<td>123</td>
<td>152</td>
<td>43</td>
<td>329</td>
</tr>
<tr>
<td>Death</td>
<td>120</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>120</td>
</tr>
<tr>
<td>Patient accidents/health &amp; safety/fire</td>
<td>0</td>
<td>3</td>
<td>24</td>
<td>103</td>
<td>70</td>
<td>200</td>
</tr>
<tr>
<td>Staff accidents/health &amp; safety/fire</td>
<td>0</td>
<td>0</td>
<td>20</td>
<td>41</td>
<td>8</td>
<td>69</td>
</tr>
<tr>
<td>Security</td>
<td>0</td>
<td>0</td>
<td>36</td>
<td>53</td>
<td>63</td>
<td>152</td>
</tr>
<tr>
<td>Confidentiality/IT/health records</td>
<td>0</td>
<td>1</td>
<td>26</td>
<td>45</td>
<td>63</td>
<td>135</td>
</tr>
<tr>
<td>MHA breach</td>
<td>0</td>
<td>0</td>
<td>15</td>
<td>75</td>
<td>20</td>
<td>110</td>
</tr>
</tbody>
</table>
3.1.1. **Violence/Aggression/Assault**

This is the highest reported category of incident within the Trust for Q1 with 1180 reported incidents. Of these the highest number were reported in CAMHS (245) followed by Croydon (245), Lambeth (155) and Lewisham (122).

![Chart 2 Reported incident type - violence/aggression/assault Q1](chart2.png)

The Trust's reducing restrictive practices committee provides oversight of the use of restrictive practices across the Trust with a focus on violence and aggression. The Trust's dashboards monitor the Trust's progress to reduce violence and aggression. Chart 2 shows the number of reported incidents over time.

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

<table>
<thead>
<tr>
<th>Table 5 Category (Clinical Care)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Category of incident (Clinical Care)</strong></td>
</tr>
<tr>
<td>Patient unwell/illness</td>
</tr>
<tr>
<td>Inappropriate behaviour (not violent)</td>
</tr>
<tr>
<td>Substance misuse - possession/supply of</td>
</tr>
<tr>
<td>Food issues</td>
</tr>
<tr>
<td>Neglect</td>
</tr>
<tr>
<td>Patient admission</td>
</tr>
<tr>
<td>Patient discharge</td>
</tr>
<tr>
<td>Patient monitoring (including pressure ulcer/wound)</td>
</tr>
<tr>
<td>Pathology test results/reports/samples</td>
</tr>
<tr>
<td>Patient financial loss</td>
</tr>
<tr>
<td><strong>Total</strong></td>
</tr>
</tbody>
</table>
There was a slight variation in the number of incidents reported under this type from 461 in Q4 to 487 to Q1, with most of these incidents reported under the category of patient admission (219). Of these 84 (38%) related to no bed available, with the majority reported under the Southwark Directorate in relation to the Acute Referral central who manage beds.

The Trust currently reviews each incident relating to MHA assessment cancellations and bed unavailability through operational meetings with Chief Operating Officer and quality meetings with Director of Nursing.

### 3.2. Serious Incidents by Directorate

Chart 4 Serious Incidents by Severity and Directorate

#### 3.3. Notified Serious Incidents
The chart below shows the spread of serious incidents across the boroughs where SLaM provides services. As expected, the boroughs with more services, particularly inpatient services have a higher number of reported incidents.

32 serious incidents were reported to commissioners in Q1, two were de-escalated on receipt of further information. Chart 4 highlights the Serious Incidents notified by CAG which commissioner is leading oversight of the investigation process.

![Chart 4](image)

**Chart 5 Serious Incident requiring investigation**

Of the 30 serious incidents requiring investigation 3 are being investigated with board level oversight and 27 are being overseen at a CAG level.

**Table 6 Serious Incidents by CCG and category**

<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>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Comprehensive (level 2)</td>
<td>1</td>
<td>2</td>
<td>0</td>
<td>0</td>
<td>3</td>
</tr>
<tr>
<td>Death</td>
<td>1</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>1</td>
</tr>
<tr>
<td>Violence/aggression/assault</td>
<td>0</td>
<td>2</td>
<td>0</td>
<td>0</td>
<td>2</td>
</tr>
<tr>
<td>Concise (level 1)</td>
<td>6</td>
<td>5</td>
<td>10</td>
<td>6</td>
<td>27</td>
</tr>
<tr>
<td>AWOL/abscond/failed to return</td>
<td>0</td>
<td>0</td>
<td>1</td>
<td>0</td>
<td>1</td>
</tr>
<tr>
<td>Death</td>
<td>5</td>
<td>3</td>
<td>6</td>
<td>2</td>
<td>16</td>
</tr>
<tr>
<td>Patient accidents/health &amp; safety/fire</td>
<td>1</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>1</td>
</tr>
<tr>
<td>Self-harm</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>6</td>
</tr>
<tr>
<td>Violence/aggression/assault</td>
<td>0</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>3</td>
</tr>
<tr>
<td>Total</td>
<td>14</td>
<td>14</td>
<td>20</td>
<td>12</td>
<td>30</td>
</tr>
</tbody>
</table>

**Table 7 Current stage of Comprehensive investigations**

**Investigations underway in Q1**

**Psychosis – Alleged homicide by community patient (SWL&STG and SLaM)**  
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. Report reviewed, awaiting final agreement from all involved.

**Acute Care – Probable Suicide of a patient who was AWOL from inpatient ward**  
Part 1 strategy meeting held, investigation team identified, investigation commenced.

**Psychosis – Alleged homicide by a community patient**  
Part 1 strategy meeting held, investigation team identified, investigation underway. Meetings with family being arranged.
### 3.4. Central Alerting System (CAS) Data

The Trust received 36 alerts from the Central Alerting System in quarter 1. Of these 4 required action, 2 were estates alerts; 1 was in relation to patients monitoring blood glucose at home, 1 patient safety alert highlighting local variation in the terminology used to describe differences in food texture. 1 alert has been acknowledged and will be assessed for relevance, all other CAS Alerts were actioned by the Trust by the deadline date.

**Table 8 CAS Alerts received in Q4**

<table>
<thead>
<tr>
<th>Type of Alert</th>
<th>Acknowledged</th>
<th>Action completed</th>
<th>Action not required</th>
<th>Response not required</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>CMO Messaging</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>3</td>
<td>3</td>
</tr>
<tr>
<td>MHRA Drug Alerts</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>4</td>
<td>4</td>
</tr>
<tr>
<td>MHRA Medical Device Alerts</td>
<td>0</td>
<td>1</td>
<td>10</td>
<td>0</td>
<td>11</td>
</tr>
<tr>
<td>NHS Improvement</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>0</td>
<td>3</td>
</tr>
<tr>
<td>NHS Improvement Estates and Facilities</td>
<td>1</td>
<td>2</td>
<td>12</td>
<td>0</td>
<td>15</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>1</strong></td>
<td><strong>4</strong></td>
<td><strong>24</strong></td>
<td><strong>7</strong></td>
<td><strong>36</strong></td>
</tr>
</tbody>
</table>

### 3.5. Inquest Data

12 inquests concluded involving Trust patients, one of which lasted 2 weeks and another two lasting 1-2 weeks. Another lasted 2 days whilst the rest were heard within a day. Attendance was required in 7 different inquests with a total of 34 staff members attending as witnesses. One inquest had 15 Trust witnesses, and another had 10.

**Chart 6 Inquests in Q1**
3.6. Claims Data

Table 9 Claims received in Q4

<table>
<thead>
<tr>
<th>Operations Directorate</th>
<th>Type</th>
<th>Number received</th>
</tr>
</thead>
<tbody>
<tr>
<td>BDP</td>
<td>Assault by Patient</td>
<td>1</td>
</tr>
<tr>
<td>CAMHS</td>
<td>Clinical negligence</td>
<td>1</td>
</tr>
<tr>
<td>Corporate</td>
<td>Asbestos exposure</td>
<td>2</td>
</tr>
<tr>
<td>Croydon</td>
<td>Assault by Patient</td>
<td>2</td>
</tr>
<tr>
<td></td>
<td>Clinical negligence</td>
<td>1</td>
</tr>
<tr>
<td>Lambeth</td>
<td>Psychological injury</td>
<td>2</td>
</tr>
<tr>
<td></td>
<td>Unlawful detention</td>
<td>1</td>
</tr>
<tr>
<td>Lewisham</td>
<td>Assault by Patient</td>
<td>3</td>
</tr>
<tr>
<td></td>
<td>Clinical negligence</td>
<td>1</td>
</tr>
<tr>
<td></td>
<td>Injured by fixed/moving object</td>
<td>1</td>
</tr>
<tr>
<td></td>
<td>Unlawful detention</td>
<td>1</td>
</tr>
<tr>
<td>Southwark</td>
<td>Assault by Patient</td>
<td>1</td>
</tr>
<tr>
<td></td>
<td>Property</td>
<td>1</td>
</tr>
<tr>
<td>Total</td>
<td></td>
<td>19</td>
</tr>
</tbody>
</table>

One of the public liability claims is for an assault, which took place 3 years ago, by a Trust patient at an acute hospital site where they were receiving medical treatment. One CNST claim relates to an incident which was investigated by the Trust and an acute hospital independently of one another.

3.7. Quality Alerts
Quality Alerts are a process to review and respond to concerns raised mainly by GPs (but also other health organisations or partners such as the police or third sector agencies) on behalf of their patients or clients. Urgent concerns about patient care are excluded from this process. During Q1 17 alerts were made to the Trust about services.

### 3.8. Complaints Data

There were 127 formal complaints received in Q1 2018-2019 compared to 138 in Q4 2017-2018 and 129 for Q3 2016-2017. 118/127 or 92.9% of complaints were acknowledged within three working days and there were 17 reopened complaints during this reporting period. 31 (24%) of complaints were identified for an Executive Level response with 96 (75.5%) responded to at Directorate Level.

![Complaints received 2013/14 - 2018/19 Q1](chart1)

**Chart 7 Complaints by quarter**

![Q1 Complaints, Compliments and Quality Alerts](chart2)

**Chart 8 Complaints, Compliments and PALS received in Q4**

The two highest subjects of complaint were issues with care and treatment and attitude/behaviour of staff. We recognise that many compliments written to services are not formally processed, many cards and thank you notes are evident in clinical services.

<table>
<thead>
<tr>
<th>Table 10 Complaints by CCG and subject</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Primary Subject</strong></td>
</tr>
<tr>
<td>Administration</td>
</tr>
<tr>
<td>Admission/Transfer Arrangements</td>
</tr>
</tbody>
</table>
### Assistance and Information

<table>
<thead>
<tr>
<th>Category</th>
<th>5</th>
<th>6</th>
<th>5</th>
<th>3</th>
</tr>
</thead>
</table>

### Attitude/Behaviour

<table>
<thead>
<tr>
<th>Category</th>
<th>10</th>
<th>14</th>
<th>7</th>
<th>10</th>
</tr>
</thead>
</table>

### Care and Treatment

<table>
<thead>
<tr>
<th>Category</th>
<th>0</th>
<th>1</th>
<th>0</th>
<th>0</th>
</tr>
</thead>
</table>

### Catering

<table>
<thead>
<tr>
<th>Category</th>
<th>0</th>
<th>0</th>
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</tr>
</thead>
</table>

### Communication

<table>
<thead>
<tr>
<th>Category</th>
<th>2</th>
<th>3</th>
<th>1</th>
<th>1</th>
</tr>
</thead>
</table>

### Discharge

<table>
<thead>
<tr>
<th>Category</th>
<th>0</th>
<th>0</th>
<th>1</th>
<th>0</th>
</tr>
</thead>
</table>

### Environment

<table>
<thead>
<tr>
<th>Category</th>
<th>1</th>
<th>0</th>
<th>1</th>
<th>0</th>
</tr>
</thead>
</table>

### Detention under the Mental Health Act

<table>
<thead>
<tr>
<th>Category</th>
<th>0</th>
<th>1</th>
<th>0</th>
<th>0</th>
</tr>
</thead>
</table>

### Other

<table>
<thead>
<tr>
<th>Category</th>
<th>0</th>
<th>1</th>
<th>0</th>
<th>0</th>
</tr>
</thead>
</table>

### Policy/Corporate decisions

<table>
<thead>
<tr>
<th>Category</th>
<th>0</th>
<th>1</th>
<th>0</th>
<th>0</th>
</tr>
</thead>
</table>

### Patient's property

<table>
<thead>
<tr>
<th>Category</th>
<th>0</th>
<th>1</th>
<th>0</th>
<th>0</th>
</tr>
</thead>
</table>

### Patient privacy/dignity/confidentiality

<table>
<thead>
<tr>
<th>Category</th>
<th>1</th>
<th>0</th>
<th>0</th>
<th>0</th>
</tr>
</thead>
</table>

### Total

<table>
<thead>
<tr>
<th>Category</th>
<th>24</th>
<th>29</th>
<th>15</th>
<th>18</th>
</tr>
</thead>
</table>

---

#### Outcomes of complaints received in Q1

- **Upheld**: 25%
- **Partially Upheld**: 24%
- **Not Upheld**: 25%
- **Passed to PALS**: 1%
- **Withdrawn**: 4%
- **No further action identified**: 7%

#### Chart 9 Complaints by outcome

**3.8.1. Top primary subjects by sub-category**

A breakdown of complaints relating to care and treatment and attitude/behaviour by sub-subject is shown in the tables below.
Table 11 Sub-subject of complaints: care and treatment

<table>
<thead>
<tr>
<th>Sub-subject of care and treatment complaints</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Co-ordination of treatment</td>
<td>22</td>
</tr>
<tr>
<td>Lack of therapies</td>
<td>8</td>
</tr>
<tr>
<td>Poor care planning</td>
<td>6</td>
</tr>
<tr>
<td>Lack of continuity</td>
<td>3</td>
</tr>
<tr>
<td>Problems with medication</td>
<td>3</td>
</tr>
<tr>
<td>Alleged assault</td>
<td>2</td>
</tr>
<tr>
<td>Behaviour</td>
<td>2</td>
</tr>
<tr>
<td>Concerns of patient's observations</td>
<td>2</td>
</tr>
<tr>
<td>Abruptness</td>
<td>1</td>
</tr>
<tr>
<td>Other</td>
<td>1</td>
</tr>
<tr>
<td>Discharged without adequate care provision</td>
<td>1</td>
</tr>
<tr>
<td>Waiting for medication</td>
<td>1</td>
</tr>
<tr>
<td>Wrong diagnosis</td>
<td>1</td>
</tr>
<tr>
<td>Poor nursing care</td>
<td>1</td>
</tr>
<tr>
<td>Treatment didn't have expected outcome</td>
<td>1</td>
</tr>
<tr>
<td>Other</td>
<td>1</td>
</tr>
<tr>
<td>Treatment against will</td>
<td>1</td>
</tr>
<tr>
<td>No communication/information provided</td>
<td>1</td>
</tr>
<tr>
<td>Confidentiality</td>
<td>1</td>
</tr>
<tr>
<td>Ignoring</td>
<td>1</td>
</tr>
<tr>
<td>Insensitive to patient needs</td>
<td>1</td>
</tr>
<tr>
<td>Lack of communication between agencies</td>
<td>1</td>
</tr>
<tr>
<td>Letter/report delayed not done in expected time frame</td>
<td>1</td>
</tr>
<tr>
<td>Reason for detention</td>
<td>1</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>64</strong></td>
</tr>
</tbody>
</table>

Table 12 Sub-subject of complaints attitude and behaviour

<table>
<thead>
<tr>
<th>Sub-subject attitude/behaviour complaints</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Behaviour</td>
<td>11</td>
</tr>
<tr>
<td>Co-ordination of treatment</td>
<td>5</td>
</tr>
<tr>
<td>Abruptness</td>
<td>4</td>
</tr>
<tr>
<td>Alleged assault</td>
<td>4</td>
</tr>
<tr>
<td>Other</td>
<td>2</td>
</tr>
<tr>
<td>Poor Care Planning</td>
<td>2</td>
</tr>
<tr>
<td>Discharged Too Early</td>
<td>2</td>
</tr>
<tr>
<td><strong>Totals:</strong></td>
<td><strong>42</strong></td>
</tr>
</tbody>
</table>

The highest number of complaints received were categorised under the sub-category of poor coordination of treatment, access to therapies and care planning. Although treatment and care outweigh other subjects cited in complaints, analysis of complaints recorded under other categories shows that these complaints are closely aligned with care and treatment concerns about administration, medication, communication with patients (and carers/relatives) about diagnosis, discharge arrangements and care plans.

Table 13 Quality Alerts

<table>
<thead>
<tr>
<th>Directorate</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Addictions</td>
<td>2</td>
</tr>
<tr>
<td>BDP</td>
<td>2</td>
</tr>
<tr>
<td>CAMHS</td>
<td>1</td>
</tr>
<tr>
<td>Lambeth</td>
<td>1</td>
</tr>
<tr>
<td>Lewisham</td>
<td>1</td>
</tr>
<tr>
<td>Psychological Medicine &amp; Older Adults</td>
<td>4</td>
</tr>
<tr>
<td>Southwark</td>
<td>4</td>
</tr>
<tr>
<td>Corporate</td>
<td>2</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>17</strong></td>
</tr>
</tbody>
</table>
3.9. Patient Advice & Liaison Service (PALS)

PALS recorded 797 enquiries in Q1; with the majority (488 or 61%) of all contacts to PALS during this reporting period received by telephone. Information requests are consistently the most frequent reason for contacting PALS quarter on quarter. Many of these single contacts are multiple in nature requiring PALS to work on several lines of enquiry and make multiple responses to the enquirer. This headline number of enquiries does not capture the actual number of queries, requests, advice, information and liaison carried out by the PALS team to meet the enquirer’s needs. PALS records are currently being updated from CAG to Operations Directorates therefore at the time of this report this data is unable to be included.

Table 14 PALS contact by Type

<table>
<thead>
<tr>
<th>PALS contacts by type</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Information</td>
<td>596</td>
</tr>
<tr>
<td>Concern</td>
<td>98</td>
</tr>
<tr>
<td>Data Protection</td>
<td>66</td>
</tr>
<tr>
<td>Crisis</td>
<td>25</td>
</tr>
<tr>
<td>Employment/Volunteering</td>
<td>5</td>
</tr>
<tr>
<td>Complaint</td>
<td>4</td>
</tr>
<tr>
<td>National Service Enquiry</td>
<td>3</td>
</tr>
<tr>
<td><strong>Total:</strong></td>
<td><strong>797</strong></td>
</tr>
</tbody>
</table>

4. Key Recommendations from the report

- Report to be made available to all services via Directorate governance meetings and through the intranet.
- Learning to be triangulated with quality improvement initiatives to identify gaps in learning.
- Delivery of cross cutting themes workshops based on independent review findings with Directorates to improve learning

The Board is asked to:

- Note the content of the report
- Make additional recommendations as required
The paper provides an update on the Mortality Review Process in the Trust, the identified learning and challenges to the process.

The Board are asked to note the paper, support the ongoing development of the review process and identified learning.

Executive summary

The paper provides an overview of the number of deaths reported and the learning identified from Mortality Reviews completed in quarter 1 (Q1) 2018/19.

During Q1 120 deaths were reported on the Datix incident reporting system. The highest number, 43, were reported in the Psychological Medicine & Older Adults. The highest reported category was natural causes, 85 (81.5%) with the remaining deaths reported under probable suicide, 16 (15.4%), accidental overdose, alleged murder of patient and death due to accidental overdose 3 (2.9%).

Within the natural causes deaths reported the causes of death included cancer, respiratory failure, COPD, cardiac arrest and pneumonia. The highest co-morbid physical health conditions identified within mortality reviews were cardiac disease (8 cases), respiratory disease (7 cases) following by diabetes (6 cases).

Of the reported deaths 75 had part 1 of the Mortality Review process completed with 70 subject to part 2 of this process. Part 1 of the Mortality Review process where deaths are coded using the adapted Mazar coding identified 47 of the 75 deaths reviewed were unexpected, included those from a natural cause. The NCEPOD grading of the 70 deaths reviewed in part 2 of the Mortality Review process identified 31 deaths (44%) where the grading was “A - A standard that you accept for yourself, your trainees and your institution” with 3 deaths (4%) graded as “E - Several aspects of clinical and/or organisational care that were well below satisfactory. Requires reporting as Serious Incident”.

The Mortality Review Group has identified that there has been a reduction in the number of mortality review forms completed, monitoring information will be included in the Mortality Review Group from September on.

Recommendations to the Board and areas for further development

Note the learning identified in this report
1.0 Introduction
This paper provides an overview of the numbers of deaths reported in quarter one (Q1) 2018/19 and the identified learning from these.

2.0 Update from the Mortality Review Group
The Mortality Review group is a sub-group of the Trust board, from July 2018 it has oversight of the Physical Health Board with a quarterly report into the Mortality Review group. Terms of reference are under review to integrate the Physical Health Board.

3.0 Reported deaths within the Trust
The electronic mortality review process has been in the Trust since January 2017. Figure 1 shows the number of deaths occurring between January 2017 – March 2018 financial year. It is important to be aware that Figure 1, Figure 2 and Figure 3 use the date of death, as such these may change on receipt of further information or there may be delays in the Trust becoming aware of the death of a patient.

![Number of deaths 01/01/2017 - 30/06/2018](chart.png)

**Figure 1 Deaths 01/01/2017 - 31/06/2018**

Figure 1 shows that the number of deaths varies with two decreases in numbers over June – August 2017 and again between April – June 2018.
The number of mortality reviews completed, Figure 2, there has been a significant drop in numbers of completed mortality reviews from March 2018 until the end of Q1. 46% of deaths within this period had a mortality review completed. This may link with the changes to the Trust’s structure from CAGs to Borough Operations Directorates. An extraordinary meeting was held in May 2018 to discuss the and agree how outstanding mortality reviews would be completed, these will be completed by the previous CAGs.

In October 2017 there were a higher number of mortality reviews with care graded below expected, however the number of deaths reported in this month were within expected limits. From November 2017 to June 2018 the grading of lower standards of care was less and the upward trend care did not continue. The number of deaths where care was rated as D to F (D - Aspects of both clinical and organisational care could have been better, E - Several aspects of clinical and/or organisational care that were well below satisfactory. or F - SI investigation initiated, unable establish at time of Mortality Review) was low, 2.9% (3) of deaths (104) in Q1 2018/19.
For the majority of mortality reviews completed, care was found to be of an acceptable or good standard which did not require further investigation through the serious incident process. Mortality reviews are completed for deaths when a patient is in receipt of treatment from the Trust or has been discharged in the past month.

4.0 Number of reported deaths in Quarter 4

Table 1 and the subsequent data is based on the reported date of deaths to the Trust, this has been used to prevent the information loss through delayed reporting/notification of a death. The Trust receives notifications of patient deaths from a range of sources including the patient’s families, the Police, the Coroner and the Office of National Statistics feed received from the CRIS team.

Table 1 Reported deaths in Q1

<table>
<thead>
<tr>
<th>Directorate</th>
<th>Category</th>
<th>Total Number</th>
<th>Number with learning disability</th>
</tr>
</thead>
<tbody>
<tr>
<td>Addictions 18</td>
<td>Alleged murder of patient</td>
<td>1</td>
<td>0</td>
</tr>
<tr>
<td></td>
<td>Natural causes</td>
<td>14</td>
<td>0</td>
</tr>
<tr>
<td></td>
<td>Probable suicide</td>
<td>3</td>
<td>0</td>
</tr>
<tr>
<td>BDP 6</td>
<td>Natural causes</td>
<td>5</td>
<td>3</td>
</tr>
<tr>
<td></td>
<td>Probable suicide</td>
<td>1</td>
<td>0</td>
</tr>
<tr>
<td>Croydon 12</td>
<td>Natural causes</td>
<td>8</td>
<td>1</td>
</tr>
<tr>
<td></td>
<td>Probable suicide</td>
<td>4</td>
<td>0</td>
</tr>
<tr>
<td>Lambeth 13</td>
<td>Natural causes</td>
<td>11</td>
<td>0</td>
</tr>
<tr>
<td></td>
<td>Probable suicide</td>
<td>2</td>
<td>0</td>
</tr>
<tr>
<td>Lewisham 20</td>
<td>Death due to accidental overdose</td>
<td>1</td>
<td>0</td>
</tr>
<tr>
<td></td>
<td>Natural causes</td>
<td>13</td>
<td>0</td>
</tr>
<tr>
<td></td>
<td>Probable suicide</td>
<td>6</td>
<td>0</td>
</tr>
<tr>
<td>Psychological Medicine &amp; Older Adults 43</td>
<td>Natural causes</td>
<td>42</td>
<td>0</td>
</tr>
<tr>
<td></td>
<td>Probable suicide</td>
<td>1</td>
<td>0</td>
</tr>
<tr>
<td>Southwark 8</td>
<td>Death as a result of a road traffic accident (RTA)</td>
<td>1</td>
<td>0</td>
</tr>
<tr>
<td></td>
<td>Natural causes</td>
<td>6</td>
<td>0</td>
</tr>
<tr>
<td></td>
<td>Probable suicide</td>
<td>1</td>
<td>0</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>120</strong></td>
<td><strong>4</strong></td>
<td></td>
</tr>
</tbody>
</table>

During Q1, 104 deaths were reported on the Datix incident reporting system. The highest number, 43, were reported in the Psychological Medicine & Older Adults. The highest reported category was natural causes, 85 (81.5%) with the remaining deaths reported under probable suicide, 16 (15.4%), accidental overdose, alleged murder of patient and death due to accidental overdose 3 (2.9%).

Of the BDP natural causes deaths; 3 occurred in community learning disabilities services – 2 patients who had known terminal illness and 1 recently referred patient who died before assessment; 1 occurred in an inpatient service and is subject to a comprehensive investigation.

The Datix incident reporting database asks if the deceased had a learning disability, even if under a non-learning disability specialist team. The field is mandatory for completion by reviewers, the clinical team is then asked to notify the death to LeDeR for further review.
Within the natural causes deaths reported the causes of death included cancer, respiratory failure, COPD, cardiac arrest and pneumonia. The highest co-morbid physical health conditions identified within mortality reviews were cardiac disease (8 cases), respiratory disease (7 cases) following by diabetes (6 cases).

When a patient is in receipt of services at the time of their death or has been discharged within one month the CAG will complete a Mortality Review Form to assess the quality of the care provided. Of the reported deaths (12), 38 had mortality review completed, NB 3 were ungraded at part 1, had part 1 of the Mortality Review process completed with 41 subject to part 2 of the process.

These reviews identified that 17 (44.7%) of the 38 deaths reviewed were unexpected, including those from a natural cause.

### Table 2 Mazar coding for reported deaths

<table>
<thead>
<tr>
<th>Mazar Framework Criteria</th>
<th>Number</th>
</tr>
</thead>
<tbody>
<tr>
<td>EN - Expected Natural (EN1): Death was expected to occur within an expected timeframe. e.g. People with terminal illness. These deaths are unlikely to be preventable.</td>
<td>8</td>
</tr>
<tr>
<td>EN2 - Death was expected but were not expected to happen in the timeframe. e.g. Someone with cancer or liver cirrhosis who dies earlier than anticipated.</td>
<td>13</td>
</tr>
<tr>
<td>UN1 - Unexpected death which are from a natural cause e.g. Sudden cardiac condition or stroke.</td>
<td>9</td>
</tr>
<tr>
<td>UN2 - Unexpected death from a natural cause but which didn't need to be e.g. Some alcohol dependency and where there may been care concerns.</td>
<td>0</td>
</tr>
<tr>
<td>UU - Unexpected deaths which are from unnatural causes e.g. Suicide, homicide, abuse or neglect.</td>
<td>8</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>38</strong></td>
</tr>
</tbody>
</table>

Part 2 of the Mortality Review Form was completed in 41 cases, the NCEPOD grading identified 21 deaths (51.2%) where the grading was “A - A standard that you accept for yourself, your trainees and your institution” with 0 deaths graded as “E - Several aspects of clinical and/or organisational care that were well below satisfactory. Requires reporting as Serious Incident”. For these cases investigators are being allocated to review the specific care problems identified either through a full serious incident review or extended review of the concerns.

### Table 3 NCEPOD coding for reported deaths

<table>
<thead>
<tr>
<th>NCEPOD Grading</th>
<th>Number</th>
</tr>
</thead>
<tbody>
<tr>
<td>A - A standard that you accept for yourself, your trainees and your institution</td>
<td>21</td>
</tr>
<tr>
<td>B - Aspects of clinical care could have been better</td>
<td>11</td>
</tr>
<tr>
<td>C - Aspects of organisational care could have been better</td>
<td>6</td>
</tr>
<tr>
<td>D - Aspects of both clinical and organisational care could have been better</td>
<td>1</td>
</tr>
<tr>
<td>E - Several aspects of clinical and/or organisational care that were well below satisfactory. Requires reporting as Serious Incident</td>
<td>0</td>
</tr>
<tr>
<td>F - SI investigation initiated, unable establish at time of Mortality Review</td>
<td>2</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>41</strong></td>
</tr>
</tbody>
</table>

Of the deaths reported in Q4, 17 were notified as serious incidents to commissioners. The review and notification process for serious incidents happens concurrently to the mortality review process. As the timescales for review and notification of serious incidents is different, cases notified to commissioners may not have been identified for immediate mortality review. It is expected that the review form will be used as part of the serious incident investigation.
Table 4 Notified investigations – mortality

<table>
<thead>
<tr>
<th>Type of Investigation/Category of incident</th>
<th>Number</th>
</tr>
</thead>
<tbody>
<tr>
<td>Comprehensive (Level 2)</td>
<td>1</td>
</tr>
<tr>
<td>Natural causes</td>
<td>1</td>
</tr>
<tr>
<td>Concise (Level 1)</td>
<td>16</td>
</tr>
<tr>
<td>Death due to accidental overdose</td>
<td>1</td>
</tr>
<tr>
<td>Natural causes</td>
<td>2</td>
</tr>
<tr>
<td>Probable suicide</td>
<td>13</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>17</strong></td>
</tr>
</tbody>
</table>

5.0 Learning identified from Mortality Reviews
The Mortality Review Group reviewed the available data using each CAGs mortality reviews in Q1 in July 2018. Attendees identified similar themes across services. Key learning points were identified as outlined below.

**Themes and learning**

**DNA and non-attendance follow up**
The follow up of patients who do not attend appointments are highlighted as a learning point.

**Cause of death**
There can be delays in the Trust receiving the cause of death from other agencies or the Coroner, which can limit the mortality review undertaken.

**Quality and completion of care plans and risk assessment**
As with the last quarter’s reviews, the quality of risk assessments and care plans was found to be variable with areas of improvement in the current stage of a details on the service user’s current situation and changes in their physical health.

**Interagency communication**
There was some evidence of excellent liaison with other services including palliative care services and home visits for patients who are difficult to engage due to their physical health. In other cases there have been difficulties in the communication between the Trust and primary care.

6.0 Conclusions and Next Steps
The Trust has seen a decrease in the number of mortality reviews completed in Q1, the Mortality Review Group will be including compliance data with the data for review by the group from September on. These outstanding mortality reviews are a priority for the Trust to complete.

Learning identified has support already identified themes including the follow up of patients who disengage, risk assessments and communication with other agencies. Learning identified is currently being reviewed locally as part of each directorate’s mortality review process.

The Trust continues to participate in the Royal College pilot to develop the standardised mortality review process for mental health.

Recommendations to the Board and areas for further development
1. Note the learning identified in this report
## Purpose of the paper

The purpose of the paper is to agree the refreshed narrative of SLaM’s strategy (Changing Lives) subject to making agreed, minor changes that will be described in the Public Board. There is a long-form and short-form strategic narrative.

This paper sets out in the executive summary a programme for engagement and consultation on Changing Lives for which approval is also sought. This includes a set of consultation events with service users, carers and their families and other community partners and stakeholders that will proceed from the Autumn and which we hope will result in additional, supporting and personalised expressions of the strategy which will also be used in communication going forwards.

Finally, the paper sets out a timetable and approach to further develop this high-level narrative into a more detailed strategic plan which is also offered for approval.

## Executive summary

In September 2017 the Board signed off the framework for the next evolution of the organisation’s strategy. This is the final draft of that strategy, called Changing Lives, which has been refreshed following a review of our priorities and initiatives, and the narrative used to describe them. A long-form and short-form narrative is included.

The strategy refresh was supported by a communications and engagement campaign including four ‘roadshow’ events where the senior management team discussed their vision for the refreshed strategy with staff. Following this, a first draft of the aims and initiatives were launched at the Trust Annual Conference on 22 March. The Council of Governors reviewed a draft of Changing Lives at their autumn away day. The strategy was amended as a result of feedback, including making staff empowerment more prominent by raising it to a main aim – a ‘great place to work’.

In addition, the description of our focus on quality and our intention to keep improving quality, which was always our primary aim, has also been strengthened in line with improvements we are actively making in clarifying our fundamental standards of care throughout the organisation and particularly in our adult acute pathway.

Agreed changes described in the Public Board will be made before publication of the strategy in October. The final, published version of the document will be presented for noting at the 30th October Board meeting.

## Engagement, consultation and communications

The strategy will be published in a digital format on [www.slam.nhs.uk](http://www.slam.nhs.uk) in October, (we are aiming for 10th
October, World Mental Health Day). Publishing in a digital format will allow us to keep refreshing our strategy and other content. Following this we will produce summary printed documents for staff and service user audiences, including easy read information.

We will be working with our service users and carers to seek their views on what the strategy means to them. Starting with the first of our borough engagement events in the autumn led by Zoe Reed, we will be led by service users and carers to produce additional, supporting and personalised expressions of the strategy which will also be used in communication going forwards and that can be fed back into our implementation work. For example, outcomes could include the production of ‘i-statements’ or a visual representation such as an ‘outcomes wall’ to reflect what changes and improvements patients and carers would like to see as a result of our strategy being put into action.

We will also include film clips alongside the published strategy – we have been working with patients and staff and started filming for a Changing Lives film that will bring the strategy to life and show how the trust is working to support recovery and help people to change their lives. A social media campaign is also raising awareness of the strategy using the hashtag #slamchanginglives

**Developing a Strategic Plan**

Taking this narrative forwards into a more detailed piece of work that will align the operational and strategic plans is programmed with a target check date of March 31st 2019. The plan would be a co-production of our borough and community partners and through working alongside the Institute of Psychiatry, Psychology & Neuroscience/Centre for Translational Informatics. When completed, we envisage this to include the following sections:

- Local population profiling with health factors
- Needs analysis (local, regional, national)
- Population/clinical outcomes we are targeting (local, regional, national/specialist)
- Description of key models of care
- Our approach to delivering population health - including supporting informatics
- Establishing the leadership, training and development needs of our people
- Clarifying our Patient and Public Involvement Priorities
- Translation into specific borough and directorate objectives – including within partnerships we operate
- Translation into specific objectives for South London Mental Health and Community Partnership
- Investments (including in Prevention, Fundamental Standards of Care and Quality Improvement, Innovation, Leadership and Workforce Development, Patient and Public Involvement, Digital, Estates etc.)
- High level workforce, activity and financial framework

The resultant operating plan for the organisation would then include outcomes, activity, workforce, cost, and investments for each directorate taking a 2-year view.

Organisation capacity to develop this plan is a real issue in light of executing ‘Our Improvement Plan’ and we are in the process of testing this issue with the executive team and the wider leadership team and will report on this at the Board.

**Risks / issues for escalation**

The strategy paper relates to all the BAF risks - as set out below.

BAF Risk 1 - Workforce - If the trust cannot attract, recruit and retain enough highly skilled staff, in the right settings with the ability to respond to organisational change the risk is that the quality of care may not be acceptable or consistent across services

BAF Risk 2 – Operational Delivery Structure - If the trust does not deliver services from an effective
operational structure, have clear care pathways and clinically driven care protocols there is a risk that there will be delays in care and that transfers between services will adversely impact the quality of care and service user experience.

BAF Risk 3 – Informatics - Failure to develop Trust informatics systems could adversely impact the quality of care, staff experience and our ability to meet contract requirements

BAF Risk 5 – Partnership working with service users - If the Trust fail to listen to the experience of people that use services and / or fail to implement the learning from all sources of adverse incidents there is a risk that services will not learn, not improve safety and present unacceptable risks for people that use services.

BAF Risk 7 – Quality & statutory compliance - In the context of significant demand, change and unpredictable clinical situations there is a potential risk that the trust will fail to deliver the necessary regulatory actions (must do's) and quality improvements identified by the CQC or meet our other regulatory duties and therefore create a risk of breaching regulation and/or statutory duties.

BAF Risk 8 – Finance contracts - If new contract values and the transitions to new contracts do not provide sufficient financial resource to deliver high quality clinical care there is a risk that the trust will not be able to provide timely access to safe high quality services across all Boroughs and care pathways.

BAF Risk 9 – Estates - The trust estate strategy will be delivered over the next 5 years and is dependent on significant capital investment. During the five years, services will continue to be delivered from buildings of differing age, quality and standards and there is a risk that the experience of staff and patients is adversely affected and that safety is compromised. Furthermore, there is a risk that developments will be unfit for purpose, delivery of major new buildings will be delayed or go over budget.

BAF Risk 11 – QI delivery - The trust estate strategy will be delivered over the next 5 years and is dependent on significant capital investment. During the five years, services will continue to be delivered from buildings of differing age, quality and standards and there is a risk that the experience of staff and patients is adversely affected and that safety is compromised. Furthermore, there is a risk that developments will be unfit for purpose, delivery of major new buildings will be delayed or go over budget.

BAF Risk 12 Finance – cost management - If services and departments do not deliver within their budgets, do not deliver the planned cost improvements, QIPPs and CQUINs and if we do not manage within Trust capacity the risk is that costs are uncontrolled and that the financial position of the Trust is destabilised which will prompt intervention by the Regulators.

BAF Risk 13 – Mandatory training - If the Trust fails to meets its mandatory training compliance targets as a result of poor local management oversight, data quality or availability of courses, there is a risk to staff and patient safety and of breaching regulation of the local training gaps with a risk to the safety of staff and patients.
Our strategy is named Changing Lives because everything we do is to help people improve their lives. We know this is what matters to our service users, carers, families, local communities and our passionate staff.

To achieve this we are focused on the quality of our services, but we cannot do this alone. We need to work in partnership with people and communities, make the trust a great place to work to attract and retain the very best people, maximise our ability to innovate, and deliver best value from all of our assets and resources.

As a large, diverse mental health trust providing local and national services, we aim to make a difference to lives by seeking excellence in all mental health and wellbeing: prevention, care, recovery, education and research.

Our Changing Lives strategy sets out five strategic aims to steer our work:

1. **Quality**: we will get the basics right in every contact and keep improving what matters to service users
2. **Partnership**: we will work together with service users, their support networks and whole populations to realise their potential
3. **A great place to work**: we will value, support and develop our managers and staff
4. **Innovation**: we will strive to be at the forefront of what is possible, exploiting our unique strengths in research and development, with everyone involved and learning
5. **Value**: we will make the best use of our assets, resources, relationships and reputation to support the best quality outcomes

One fundamental shift that we want to make is to change the relationship with service users, carers and families at all levels. We have already made strong progress but we need to support both professionals and service users to take different roles and approaches that will help people change their lives. Our well-established five commitments to build trusting, mutual relationships set us on good course for this.

The Changing Lives strategy builds on our direction of travel, evolving from our previous strategy, but with stronger emphasis on consistent quality, continuous improvement and partnership in its different forms. The strategy is aligned with a wide range of partners (Clinical Commissioning Groups, STPs, South London Partnership, Healthy London Partnership, the Maudsley Charity, King’s College London’s IoPPN) and will engage an increasingly wide range of partners such as schools, employers, voluntary sector, community and faith groups.

We will continue to evolve our strategy in light of views from stakeholders and as we review its delivery and impact.

As a trust, we have already agreed our quality priorities. Next, working with our stakeholders, we will define a set of meaningful and stretching outcome measures that cover the breadth of our work across adult and children’s services and population health to research and innovation.
We are immensely grateful to our staff, service users and stakeholders for their insights in steering the direction of the trust and our quality priorities and we will continue to listen and respond to the views we hear.

Our vision

Everything we do is to improve the lives of the people and communities we serve and to promote mental health and wellbeing for all - locally, nationally and internationally

Our mission

Seeking excellence in all mental health and wellbeing: prevention, care, recovery, education and research

Our quality priorities

1. All patients will have access to the right care at the right time in the most appropriate setting
2. Within three years, we will routinely involve service users and carers in all aspects of service design, improvement and governance; and all aspects of planning and delivery of each individual’s care
3. Over the next three years, we will enable staff to experience improved satisfaction and joy at work.
4. We will reduce violence by 50% over three years with the aim of reducing all types of restrictive practices

Our five commitments - to build trusting, mutual relationships with each other and with service users (these are expected of everyone and were developed with staff and checked with service users)

1. I will be caring, kind and polite
2. I will be prompt and value your time
3. I will take time to listen to you
4. I will be honest and direct with you
5. I will do what I say I am going to do
Our strategic aims

**Quality**: we will get the basics right in every contact and keep improving what matters to service users

Our ambitions

As an organisation, our focus has to be on delivering the best possible care for everyone who comes into contact with our services, on every day and on every site – safe, effective and caring. We must provide consistency in the quality of care.

We will achieve the best possible outcomes and experience for service users through a focus on leadership, the fundamental standards of care, continuous quality improvement and developing new models of care. Quality is at the heart of our culture. We are developing a culture where everyone has a mindset for continuous improvement and focuses on outcomes that matter to people who use our services and their friends, families and carers. We are improving our acute care pathway. In particular, we are working to reduce the level of unwarranted variation in the quality care across our acute wards and Psychiatric Intensive Care (PICU) services.

Two years ago we committed to QI through our partnership with the Institute for Healthcare Improvement (IHI). Now, QI is becoming strongly embedded across the Trust as core to how we work and Executive and Board leadership is highly visible.

Our initiatives

- Leadership for quality
- Fundamental standards of care – priority areas for improvement across the organisation
- Fundamental standards of care – acute care pathway services
- Quality improvement
- New models of care
**Partnership:** we will work together with service users, their support networks and whole populations to realise their potential

**Our ambitions**

We will make a step change in working collaboratively with service users, carers and families. We will work together with people to plan care, to understand them and their carers, to maximise their control, and bring together services to achieve the outcomes important to them.

We will support people to develop the knowledge, skills and confidence they need to more effectively look after themselves and make informed decisions about their own health and well-being. We recognise adopting person-centred care as ‘business as usual’ requires fundamental changes to how services are delivered and to roles - not only those of health care professionals, but of service users too - and the relationships between service users, professionals and teams. Staff, service users and carers need to recognise that each play a vital role in the wellbeing of the person needing our help and the power imbalance between the three parties needs to be acknowledged and addressed. Genuine coproduction will mean that people’s cultural needs will be met because their assets, needs and wants will be at the heart of what we develop to support them when they have mental health difficulties.

We will work collaboratively with our local partners to provide joined up care, close to home and focus on key outcomes that matter to local people. We will focus on prevention, access, early intervention and recovery to improve our reach and positive improvement for people's lives. To drive primary prevention, we will work with a wide range of partners - schools, the policy, local government and housing – developing and sharing the evidence about what works and helping educate people about mental health. Embracing partnership working and forging local connections, relationships and partnerships will help develop a collaborative movement to improve life opportunities. This will build on our existing work in Lambeth where resources have been pooled to prevent long in-patient stays for patients and for older adults in Croydon.

**Our initiatives**

- Working in partnership with people who use services, their friends, families and carers and members of local communities:
- Partnerships to help local communities realise their potential
- A joined up approach to Mind and Body and physical healthcare
A great place to work: we will value, support and develop our managers and staff

Our ambitions

The quality of care that service users receive depends first and foremost on the skill and dedication of our staff. We know that staff who are engaged, happy and supported at work provide the best care. Our passionate staff do a difficult job, often in challenging circumstances and there is more we can do to improve their experience, satisfaction and joy at work and equip them to deliver quality care. This will come from listening to their views and valuing their contribution as well as offering opportunities to develop new skills and career progression as part of their continuous development, and investing in staff wellbeing. Making the trust a great place to work will help us continue to attract and retain the very best people.

Our initiatives:

- A new recruitment and retention strategy with increased investment:
- Step change in training, education and development opportunities
- A comprehensive nursing development programme
- Health and well-being
- Develop our Freedom to Speak Up structure
- Improve change management
- Leadership development and organisational development
- Develop and deliver equalities strategy
- Staff communications
- Staff recognition

Innovation: striving to be at the forefront of what is possible, exploiting our unique strengths in research and development, with everyone involved and learning

Our ambitions

We will maximise how service users and the local community benefit from research and development by making it a routine, core part of clinical activities across the organisation - in all professional groups and more teams across our geography. This will build on our unique breadth and depth of research and clinical care with many clinical areas already having strong research programmes informing local, national and international practice. Leading edge big data and digital approaches will allow us to identify people at risk, identify issues and develop new interventions and deliver support and improve care.

We will answer key questions in clinical practice and population health, informing our work in the trust and that of mental health practitioners across the globe. Groundbreaking discoveries will be made and new practices introduced, refined and evaluated through our extensive clinical academic partnerships to establish evidence-based practice. Our care pathways will be underpinned by research and evidence supporting the highest possible standards of care. We will increase the number of SLaM staff involved in research by encouraging and supporting all staff to get involved and take more active roles in leading research and take pride in being part of a research active organisation.
Quality improvement approaches will be used to put evidence-based practice into wider use and to become a true learning organisation and system. Our approach to education and training will support staff to get involved in both research and quality improvement which will help to further develop an ethos of innovation as we develop our workforce and our clinical services.

The Maudsley Charity is one of the larger hospital charities and able to make a significant difference to innovation in the trust. It works closely with our staff to generate ideas that will make a difference to care, treatment and service innovation.

As a Trust, our relationship with academic mental health and the world leading reputation of the Maudsley brand in research and innovation is perhaps what we are most known for. As such leaders for mental health, we will use the insight and our voice to improve care nationally and internationally and tackle stigma and discrimination.

Our initiatives

- Our R&D strategy supports active research and the translation of evidence and research into clinical practice and population health
- Develop the SLaM-IoPPN Centre for Translational Informatics
- Create a new Centre for Young People’s Mental Health
- Develop our education and training strategy
- Launch Maudsley Learning to make a step change in our work as a lead provider of education and training

**Value:** making the best use of our assets, resources, relationships and reputation to support the best quality outcomes

Our ambitions

We will ensure our care services and support services provide the best possible value by focusing on the outcomes we achieve for the resources. Being financially sustainable and governed to the highest possible standards is a core focus with a strong interface between performance, finance and quality. We will manage our costs effectively so we can re-invest in our people, innovation, research and training. Reducing clinical variation will provide better value. Commercial ventures will allow us to reinvest in staff development, innovation and local services at a time when these budgets are under pressure. Staff will be able to make the best use of information with reliable IT infrastructure and applications and data to support quality improvement and innovation. Our staff and service users will benefit from being in places we are proud of.

Our initiatives

- Continue to develop our leadership and governance
- Take forward our 5 year financial strategy
- Commercial development
- Deliver improvements to the quality of our estates and facilities
- Progress on implementing our digital strategy and becoming a Global Digital Exemplar
Our strategy is named *Changing Lives* because everything we do is to help people improve their lives. We know this is what matters to our service users, carers, families, local communities and our passionate staff.

To achieve this we are focused on the quality of our services, but we cannot do this alone. We need to work in partnership with people and communities, make the trust a great place to work to attract and retain the very best people, maximise our ability to innovate, and deliver best value from all of our assets and resources.

As a large, diverse mental health trust providing local and national services, we aim to make a difference to lives by seeking excellence in all mental health and wellbeing: prevention, care, recovery, education and research.

Our *Changing Lives* strategy sets out five strategic aims to steer our work:

1. **Quality**: we will get the basics right in every contact and keep improving what matters to service users
2. **Partnership**: we will work together with service users, their support networks and whole populations to realise their potential
3. **A great place to work**: we will value, support and develop our managers and staff
4. **Innovation**: we will strive to be at the forefront of what is possible, exploiting our unique strengths in research and development, with everyone involved and learning
5. **Value**: we will make the best use of our assets, resources, relationships and reputation to support the best quality outcomes

One fundamental shift that we want to make is to change the relationship with service users, carers and families at all levels. We have already made strong progress but we need to support both professionals and service users to take different roles and approaches that will help people change their lives. Our well-established five commitments to build trusting, mutual relationships set us on good course for this.

The *Changing Lives* strategy builds on our direction of travel, evolving from our previous strategy, but with stronger emphasis on consistent quality, continuous improvement and partnership in its different forms. The strategy is aligned with a wide range of partners (Clinical Commissioning Groups, STPs, South London Partnership, Healthy London Partnership, the Maudsley Charity, and the Institute of Psychiatry, Psychology and Neuroscience (IoPPN) at King’s College London) and will engage an increasingly wide range of partners such as schools, employers, voluntary sector, community and faith groups.

We will continue to evolve our strategy in light of views from stakeholders and as we review its delivery and impact.
As a trust, we have already agreed our quality priorities. Next, working with our stakeholders, we will define a set of meaningful and stretching outcome measures that cover the breadth of our work across adult and children’s services and population health to research and innovation.

We are immensely grateful to our staff, service users and stakeholders for their insights in steering the direction of the trust and our quality priorities and we will continue to listen and respond to the views we hear.

How we will know we are on track – what matters to staff and service users

Increasing numbers of staff will say:

- They feel trusted, listened to and valued at work and fairly treated.
- They are supported by their managers and senior managers are involved with their work.
- They feel safe at work.
- They have the resources to deliver high quality care for service users - support, tools and training.
- They are supported to work in partnership with service users and carers
- They are working collaboratively with others in primary care, community services, housing, social care and the voluntary and community sector.
- They have the chance to develop their potential, including through high quality education and training.
- They understand how their role fits in.
- They are able to improve the way they work in their team and contribute to improvements across services and the organisation. They feel empowered to influence change wherever they work.
- They are involved in research and putting evidence into practice, constantly learning and improving services.
- They are proud of the services and treatments the trust offers and the difference they make to service users.

Increasing numbers of service users will say:

- They get the right support as an individual to stay healthy and recover - both their physical and mental health.
- The support that they receive helps them to build up their confidence and independence so they don’t become dependent on services.
- They receive early support that helps them to avoid reaching crisis point.
- They are treated with dignity and respect if they experience mental health crisis.
- They feel well informed and am comfortable to talk about mental health and wellbeing.
- They know where to go if they feel that they need support
- They can choose support that they feel is suitable for them and their network from a range of different offers.
- They receive support which builds upon their strengths, abilities and aspirations.
- They (and their support networks) feel respected as key partners in decision making.
- They feel that they have an active and equal role in the design and delivery of
- They spend less time in hospital and receive care at home and in the community. They are able to live in a place of their own choosing
- They are treated in facilities and environments that are clean, decent and therapeutic.
- They have a meaningful day-to-day role in society that suits them
- They feel connected to and supported by other people in their community and networks.
- They have the opportunity to get involved in research and leading edge services and treatments.

Our vision
Everything we do is to improve the lives of the people and communities we serve and to promote mental health and wellbeing for all - locally, nationally and internationally

Our mission
Seeking excellence in all mental health and wellbeing: prevention, care, recovery, education and research

Our quality priorities
1. All patients will have access to the right care at the right time in the most appropriate setting
2. Within three years, we will routinely involve service users and carers in all aspects of service design, improvement and governance; and all aspects of planning and delivery of each individual’s care
3. Over the next three years, we will enable staff to experience improved satisfaction and joy at work.
4. We will reduce violence by 50% over three years with the aim of reducing all types of restrictive practices

Our five commitments - to build trusting, mutual relationships with each other and with service users (these are expected of everyone and were developed with staff and checked with service users)
1. I will be caring, kind and polite
2. I will be prompt and value your time
3. I will take time to listen to you
4. I will be honest and direct with you
5. I will do what I say I am going to do
**About our trust**

South London and Maudsley NHS Foundation Trust (SLaM) is a large and complex multi-site provider of mental health services - providing the widest range of specialist mental health services in the UK.

**Local services** We provide local services to four diverse and vibrant south London boroughs, each characterised by high levels of deprivation and need. We aspire to help people stay well in the community and to help and support people to recover when in difficulty. We provide NHS care and treatment for people with mental health problems. We also provide services for people who are addicted to drugs or alcohol.

We are at the leading edge of integrated care for mental health, involved in the largest alliance contract in the country in Lambeth (comprising SLaM, Lambeth Council, the CCG and two voluntary sector housing and care providers), a second alliance providing care to the over 65s in Croydon, and working towards population scale partnership contracts in Lewisham and Southwark.

We work with Oxleas NHS FT and South West London and St George’s NHS Trust to collaborate to provide more sustainable healthcare in South London through the South London Mental Health and Community Partnership (formed in 2016).

**National, specialist services** We also provide a wide range of high-quality, national specialist services for those with complex and intensive care mental health services - over 50 specialist services for children and adults across the UK. These include a Mother and Baby Unit, Eating Disorders, National Psychosis Unit and National Autism Unit. Some of our clinical and academic developments have international reach.

**Research and education and training**

The trust’s approach also reflects the mission of our Academic Health Sciences Centre, King’s Health Partners, to pioneer better health and well-being, locally and globally, through integrating excellence in research, education and training, and patient care.

The trust has an historic association with our close academic partner, the Institute of Psychiatry, Psychology and Neuroscience (IoPPN) at King’s College London. The IoPPN is Europe’s largest centre for research in psychology and psychiatry and we have the highest research profile of any mental health Trust in the UK.

Our National Institute for Health Research (NIHR) Maudsley Biomedical Research Centre illustrates the symbiotic partnership working between the trust and the IoPPN.

The independent Maudsley Charity backs better care, recovery and prevention of mental illness. It supports service users and families, clinical care teams and scientists who are working towards the common goal of improving mental health, and raises public awareness and understanding.
We provide:

- mental health services for people living in Croydon, Lambeth, Southwark and Lewisham
- substance misuse services for residents of Lambeth, Bexley, Greenwich and Wandsworth
- specialist services for young people in Kent and Medway who require hospital admission for serious mental illness and outpatient treatment for adults with ADHD
- primary care, secondary care and inpatient mental health services in HMP Wandsworth
- a range of mental health services internationally, in Europe and the Middle East
- the largest mental health research and development portfolio in the country
- an extensive range of education, training and learning opportunities – including the Recovery College and Mental Health Simulation Centre.

The Trust in numbers

1.1 million patient contacts each year

NUMBER OF STAFF 4,800

COMMUNITY, INPATIENT AND OUTPATIENT SERVICES 230

We serve a population of 1.3 million people

The national picture
High and growing demand

- Half of all mental health problems have been established by the age of 14, rising to 75 per cent by the age of 24.
- One in four adults and one in 10 children experience mental illness, and many more of us know and care for people who do.
- One in six adults at any one time are experiencing a common mental health problem such as anxiety or depression.
- Currently two-thirds of people with anxiety and depression access no treatment.
- One in five older people living in the community and 40 per cent of older people living in care homes are affected by depression.
- Nationally, one in five mothers suffers from mental health problems during pregnancy or in the first year after childbirth. Yet fewer than 15% of areas have the necessary perinatal mental health services and more than 40% provide none at all.

According to The Adult Psychiatric Morbidity Survey (APMS):
- The prevalence of psychotic disorder is about 0.5% of the adult population.
- 0.8% of adults have autism spectrum disorder (ASD).
- For those aged 16 and older, over 1 in 10 (13.7%) have a personality disorder, with similar rates found for both men and women.
- About one third of adults in England report having experienced at least one traumatic event in their lifetime. Around, 4.4% of adults screened positively for PTSD.
- About 10% of adults screened positively for attention deficit hyperactivity disorder (ADHD).
- Suicide is rising, after many years of decline. Suicide was the leading cause of death for men under 50 years of age in England and Wales, and for women aged 20–34.
- 1 in 15 people (7.3%) had self-harmed at some point in their life. This was higher in women (8.9%) than in men (5.7%).
- By 2030 there will be 2 million more adults in the UK with mental health problems than today.
- There are rapidly changing public expectations and behaviours around mental health.

Treating mental and physical health equally

People with mental health problems receive poorer physical health care and the average life expectancy for someone with a long-term mental health illness or learning disability is 15-20 years shorter than for someone without. Someone with serious mental illness is three times more likely to attend A&E and almost five times more likely to be admitted as an emergency. Thirty per cent of people with a long-term condition also suffer from poor mental health.

Government priorities

The Five Year Forward View for Mental Health sets out ambitions to:
- Achieve parity of esteem between physical and mental health across the life course.
- Provide access to good quality, integrated mental health care, wherever and whenever individuals are seen across the NHS
- Tackle inequalities both at a local and national level

Meeting the ambitions for the Five Year Forward View for Mental Health describes how the ambitions will be delivered:
- Establish services which are sustainable for the long-term across the health and care system
- Deliver improved access to high-quality care, more integrated services and earlier interventions.
- Build capacity within community-based services to reduce demand and release capacity from the acute sector and in-patient beds – whilst in parallel moving the commissioning model for in-patient beds in mental health towards
a more ‘place-based’ approach so that pathways and incentives are better aligned and efficiencies more readily realised.

- Coproduction with people with lived experience of services, their families and carers
- Work in partnership with local public, private and voluntary sector organisations. Recognising the contributions of each to improving mental health and wellbeing;
- Identify needs and intervening at the earliest appropriate opportunity to reduce the likelihood of escalation and distress and support recovery
- Design and deliver person-centred care, underpinned by evidence, which supports people to lead fuller, happier lives
- Outcome-focused, intelligent and data-driven commissioning.

Immediate priorities for service redesign:

- Increase access to specialist perinatal care
- Reduce the number of out of area placements for children, young people and adults through the provision of more care closer to and at home
- Increase access to crisis care liaison services in emergency departments and inpatient wards
- Suicide prevention.

The mental health workforce plan for England describes how the mental health workforce will be developed to address shortages and meet the needs

The local picture

The boroughs we serve are wonderfully diverse and vibrant with a wealth of strong community assets and a strong sense of local identity that celebrates the diverse backgrounds of residents which contribute positively to the mental health and wellbeing of residents.

However, the risk of poor mental health is particularly high in our four boroughs which are some of the most deprived in London and the UK (among the 20% most deprived areas in England). Rates of mental illness are higher than England and London. There is a higher need for both psychiatric services (approximately 20-55% higher than England across the boroughs) and higher prevalence of common mental health issues than London and England averages. The economic downturn has affected disadvantaged communities the most and we are seeing this played out in the demand for our services.

Premature death and differences in life expectancy are both significant issues. In south London, serious mental illness reduces a person's life expectancy by 15-20 years.

It is a challenging environment in terms of financial resources available to commissioners. Each of our Clinical Commissioning Groups (CCGs) is committed to mental health as a high priority and recognise the historic challenges e.g. all the boroughs served by the trust are in the bottom quintile in the country for resourcing mental health per 100,000 weighted population and bed stock and community investment per 100,000 weighted population is also in the lowest quintile for the country. However, they are committed to meeting the Mental Health Investment Standard (MHIS) and recognise the systemic nature of many of the challenges we face.

Alongside all public services, the NHS has been set high savings targets over the past few years - the cumulative efficiency target over the last seven years is over 21%. Such levels of savings are an increasing challenge at a time when pressures on services continue to mount. Our four main local CCGs that together provide approximately 60% of our total income require additional savings as part of their Quality Innovation,
Productivity and Prevention (QIPP) programme which need to be through planned developments or service changes.

Our addictions services will continue to operate in a highly competitive market, with local authority budgets under enormous pressure.

Our greatest challenges are around demand and flow management within our acute care pathway and inpatient provision, and ensuring this does not impact on the consistency of care, patient experience and outcomes.

A snapshot of the needs of our four local commissioning boroughs

**Addressing the wider determinants of health remains the key to improving mental health and wellbeing**

**DETERMINANTS OF POPULATION MENTAL ILL-HEALTH**

**RISK FACTORS**
- Poverty, deprivation and high debt
- Unemployment, job stress, job insecurity
- Substance misuse
- Learning difficulties or special needs
- Family disharmony, abuse, neglect, bullying or discrimination

**PROTECTIVE FACTORS**
- Healthy prenatal and childhood environment
- Social relationships
- Social capital
- Healthy lifestyles
- Employment prospects and healthy workplace
**Croydon**

Croydon has the highest population in London with residents from a wide range of ethnic origins and cultures. In the north, Croydon is a metropolitan area whilst to the south it sprawls into green leafy suburbs. There is an increasing demand for mental health services (led in part by demographic changes and rapid population growth), which has led to significant pressures on inpatient beds for Croydon’s population. As a result of migration flows, Croydon’s population is likely to become more deprived. Over half of Croydon’s population are from black, Asian and minority ethnic groups and this proportion is increasing over time. Whilst the common mental health disorders such as anxiety and depression are projected to increase by 5% over ten years, a much greater increase is projected in people with serious mental illness. Numbers of people with schizophrenia, bipolar disorder and other psychoses are projected to increase by 23% by 2021. The need for mental health services varies across the borough with greater need in the north and east. Croydon has a low baseline for community services and is seeing a level of demand for talking therapies that current provision is not meeting.

**Lambeth**

Lambeth is a thriving central London borough with a diverse and changing population. It’s a microcosm of the global trend towards urbanisation; with population growth, successful businesses, opportunities for creativity and redevelopment abound. The borough’s patchwork of communities, town centres, neighbourhoods and open spaces all have their own story, and they all feed into why Lambeth is such a special place. Lambeth is the 44th most deprived local authority in England and the 9th most deprived borough in London with 36.7% of the population living in the 20% most deprived areas in Lambeth and one third of families with children are in receipt of benefits. Lambeth has the fourth highest turnover of residents in England - 40,000 people leave the borough, and over 40,000 others move to the borough every year. It has a predominantly younger population, 44%, aged 20 to 39 years old compared with 27% in England. Lambeth is ethnically diverse - 60% of Lambeth’s population describe their ethnicity as other than white British; 30% Black ethnicity compared to 17% in London. Having a multicultural community is seen by residents as one of the top most important things in making Lambeth a good place to live and community cohesion is very high. Priorities for the borough are to continue bring investment into the borough ensuring that this helps and touches people’s lives, to tackle the inequality in the borough and the supporting strong and sustainable neighbourhoods. Lambeth has one of the highest levels of mental illness in England. In 2013/14, 1.3% of all patients in GP practices in Lambeth were on the serious mental illness register. The English average is 0.85%. The rate of premature mortality in adults with serious mental illness is significantly lower in Lambeth at 691 per 100,000 compared to England (1319 per 100,000). Faced with a tight budget and fragmented services Lambeth’s CCG and council have taken the radical step of pooling budgets and services into the Living Well Network Alliance to design, develop and deliver a new model of adult mental health services in Lambeth.

**Lewisham**

Stretching from the banks of the Thames, in the north, to the borders with Bromley, in the south, Lewisham encompass strong communities who take pride in their local areas and neighbourhoods. Lewisham is one of the greenest parts of south-east London. The Health and Wellbeing Strategy for Lewisham identifies mental health and wellbeing as a priority area given there are high levels of mental health need in the borough: Approximately 10-20% of women are affected by mental health problems at some point during their pregnancy or the first year after childbirth. There are higher rates of serious mental illness (SMI) in Lewisham compared to London and England as a whole; one in 16 adults in Lewisham were affected by depression - this is lower than the national average but higher than in London overall; the suicide rate has fallen but is not significantly below the London or national average. There are high rates of mental health service use: Lewisham has a consistently higher number of patients with severe mental illness on the Care Programme Approach in comparison to the neighbouring boroughs of Lambeth and Southwark; Black and minority ethnic (BME) residents are underrepresented in referrals to the local Improving Access to Psychological Services (IAPT); Lewisham residents were more likely to have a high anxiety score on ONS Wellbeing Measures in comparison to London and England overall; there is an upwards trend in the number of patients detained under the Mental Health Act in Lewisham. Within Lewisham there is variable need for mental health services, with the southern wards of the borough (Downham, Bellingham and Whitefoot) estimated to have a 25 – 40% higher need for services, in contrast...
to more affluent wards such as Forest Hill and Catford South that have lower need than the national average.

**Southwark** Southwark is a densely populated and diverse inner London borough situated on the south bank of the River Thames. Home to over 314,000 people, Southwark is a patchwork of communities: from leafy Dulwich, to bustling Peckham and Camberwell, and the rapidly changing Rotherhithe peninsula. It is predicted that by 2026 the population will grow by 20%. It is a young borough with the median age of 32.9 years. Southwark is a home to multiple ethnic groups with just over a half of residents coming from a White ethnic background, around a third of from Black ethnic background and the remaining fifth from mixed, Asian and multiple other ethnic groups. Southwark is 40th most deprived local authority and ninth most deprived out of 33 London local authorities. There is a significant variation in deprivation across the borough with around 38% Southwark residents living in areas which are among the most deprived nationally. It is estimated that almost one in five adults in Southwark are experiencing a common mental disorder. The prevalence of severe mental illness in Southwark is 1.4% (approximately 3,800 patients) and severe mental illness disproportionately affects male, older and black ethnic population groups. Suicide is seen as a proxy for underlying rates of mental ill-health; in 2013/15 Southwark was one of five London boroughs to report higher suicide rates than the national average. Approximately half of the claims for employment and support allowance (ESA) are related to mental health. Southwark’s rate of mental health admissions and detentions under the Mental Health Act are comparable to the STP footprint but are substantially higher than national averages.

<table>
<thead>
<tr>
<th>Mental health priorities of South East London STP, including Lambeth, Lewisham and Southwark</th>
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<tbody>
<tr>
<td><strong>We want to stop treating the mind and body separately. We want our services to assess and treat mental health disorders or conditions on a par with physical illnesses.</strong></td>
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<tr>
<td><strong>Prevention</strong> We are working to develop a consistent approach to recognise and support people with mental health needs. More screening and ensuring timely access to evidence-based care is essential.</td>
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<tr>
<td><strong>Integrated care</strong> We want mental health services to become more integrated in all our health and care services.</td>
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<tr>
<td><strong>Perinatal mental health</strong> In south east London we want all women to have access to perinatal mental health services.</td>
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<tr>
<td><strong>Easier and faster access to crisis mental health services</strong> We are working to make sure there is access to mental health support and liaison teams for people of all ages in our A&amp;E departments 24 hours a day, 7 days a week. We also want to make it easier to access community based crisis response teams and intensive home treatment as an alternative to hospital.</td>
</tr>
<tr>
<td><strong>People who need inpatient care</strong> We want to make sure that if someone is in crisis, they can access a health-based place of safety - somewhere where mental health professionals can assess a person's needs and work out the best next steps.</td>
</tr>
</tbody>
</table>
We need to do more around **prevention and early intervention**, to help keep people well and get them the support they need as early as possible.

We need to **improve support for people with long term conditions**, whose mental health is often not dealt with, or dealt with separately from their physical health needs.

We need to provide **better care for both young people and adults** experiencing a mental health crisis, including alternatives to admission and improved pathways for those people with a mental illness who are removed from a public place by either the police or by medical services (known as the s136 pathway), and ensuring people experiencing first episodes of psychosis receive timely treatment.

We need to provide better support for the 3-5% of women who experience moderate to severe mental health problems during **the perinatal period**

We need to improve support to **people at risk of suicide**.
Our strategic aims

Quality: we will get the basics right in every contact and keep improving what matters to service users

Our ambitions

As an organisation, our focus has to be on delivering the best possible care for everyone who comes into contact with our services, on every day and on every site – safe, effective and caring. We must provide consistency in the quality of care.

We will achieve the best possible outcomes and experience for service users through a focus on leadership, the fundamental standards of care, continuous quality improvement and developing new models of care. Quality is at the heart of our culture. We are developing a culture where everyone has a mind set for continuous improvement and focuses on outcomes that matter to people who use our services and their friends, families and carers.

We are improving our acute care pathway. In particular, we are working to reduce the level of unwarranted variation in the quality care across our acute wards and Psychiatric Intensive Care (PICU) services.

Two years ago we committed to QI through our partnership with the Institute for Healthcare Improvement (IHI). Now, QI is becoming strongly embedded across the Trust as core to how we work and Executive and Board leadership is highly visible.

Our initiatives

Leadership for quality

- New leadership teams with a focus on quality and quality improvement – operations directors to deliver consistency in the quality of care required in each borough and trust-wide for smaller, national and specialist services.
- A new quality centre to monitor and drive quality across the organisation, including seven Clinical Academic Groups to focus on: clinical outcomes, quality improvement, business intelligence, education and training, evidence and research and to enable the development of new clinical pathways, pathway protocols and development priorities.
- Define outcome measures for adult and older adult services and children’s services covering both inpatient and community care and overarching outcome measures for the strategy.
- Take forward our trust wide Serious Incident (SI) group with Clinical Director accountability and stakeholder representation.
- Equip everyone with the skills and support to improve quality across the organisation.

Fundamental standards of care – priority areas for improvement across the organisation
Care plans: we will improve how service users are involved in all aspects of their care ensuring that people are actively engaged in developing crisis and recovery plans that work for them, managing expectations and being clear about choices.

Environments that are safe: we are introducing a trust-wide programme to reduce ligature anchor points to ensure patient safety.

Reducing violence and restraint: we will reduce violence by 50% over three years with the aim of reducing all types of restrictive practices.

Drive to achieve standards for access, assessment, treatment and helping people stay well

Safe staffing: we will ensure every ward and every community team is staffed appropriately.

Fundamental standards of care – acute care pathway services

We are improving local leadership by:

- **Bringing together the acute care pathway:** teams providing acute inpatient and community care will take forward recent improvements– the single place of safety, the ARC (our single bed management hub), and the relationship between Home Treatment Teams (HTTs) and the wards.
- **Borough-based directorate leadership** will allow the new leadership teams to get to know their patch in much greater detail and align closely with other partners including social care, the voluntary sector, housing and other community assets.
- **Joint working between medical and nursing leads and service directors** and OT and Psychology leads will impact on culture and behaviour across our acute and crisis care pathway.

Governance: We will embed improved ward-to-directorate governance as a part of the borough reorganisation.

Pathway flow and discharge planning: We will improve flow through our acute pathway, linked with bed availability and team caseloads, working with our system partners.

Development of trust-wide QI programme of work within our general adult services – iCare – which addresses crisis and relapse prevention, safety in the community and safety in inpatient services.

Quality improvement

- Develop use of the Trust dashboard (called Deming) which is a quality dashboard that draws data from records. Teams will be able to monitor activity through trust-wide, team and individual-level visual dashboards. This will enable the Trust to use data more robustly to inform decisions, improvements and track change over time enabling continuous improvement.
- Continue with our major trust-wide QI programme ‘Four Steps to Safety’ on reducing violence and aggression.
- Scale up successful QI projects – there are over 100 live QI projects across the organisation focused on fundamental standards of care.
- Continue to develop how we coproduce QI projects with service users and with community members through the Joint Working Groups in each Borough.
- Continue to hold both QI and Safety Huddles weekly.
- Build capacity and capability through our set of QI development programmes from foundation to expert and QI coach development across the directorates and corporate services – there are already over 700 staff trained at different levels. One programme is coproduced with and codelivered with service users in the Recovery College
- Learning from our Serious Incident reports – asking why, why, why questions.

New models of care

- We will shape our model for integrated care, including in a community setting.
- Improve the delivery of our national and specialist services through clinically-led development of new models of care and continuous quality innovation, working with our partners in Oxleas and South West London and St George’s (our South London Mental Health and Community
Partnership) e.g. forensics and CAMHS; improving crisis care and alternative to admission services for children and you people.

- We are driving the development of an ambitious new Centre for Young People’s Mental Health that will deliver new models of care and discoveries about how to improve outcomes – earliest opening date of May 2022. This will include engaging staff, stakeholders and local communities in awareness raising and fundraising.

- New models of care supported by digital approaches, including our Personal Health Record platform Healthlocker to equip people when they use our services and their families to self-manage their conditions and get digital access to their health records, online resources and care plans. Digital technology will extend our reach by enabling service users to provide useful information so that we and they can monitor how things are going between appointments.

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**South London Mental Health and Community Partnership**

Together, we deliver two New Models of Care (forensics and tier 4 CAMHS) that have already made real differences to patient experience and outcomes, resulting in fewer patients placed out of the area in beds outside our trusts.

The new Acute Referral Centre is helping to maintain an up-to-date position on bed occupancy and provides links with our community teams.

We also work together on a wide range of activity from pharmacy (improving prescribing in schizophrenia) to nursing and workforce (with a staff passport, harmonised nursing career structure, and close to £2m committed to training Nursing Associates).

As a partnership, over the past 18 months we have committed £4.6m into the development of new services for local people. Clinically led but working in partnership with service users, carers and communities has been key to these developments.

Looking forward, priorities include:

- Launching a Forensics CAMHS service
- Expanding CAMHS Crisis Care services
- Increasing community Dialectic Behaviour Therapies interventions for children and young people, particular in south east London
- Starting to take on commissioning and support for Complex Care patients
- Piloting new Band 5 community nursing roles
**Partnership:** we will work together with service users, their support networks and whole populations to realise their potential

**Our ambitions**

We will make a step change in working collaboratively with service users, carers and families. We will work together with people to plan care, to understand them and their carers, to maximise their control, and bring together services to achieve the outcomes important to them.

We will support people to develop the knowledge, skills and confidence they need to more effectively look after themselves and make informed decisions about their own health and well-being. We recognise adopting person-centred care as ‘business as usual’ requires fundamental changes to how services are delivered and to roles - not only those of health care professionals, but of service users too - and the relationships between service users, professionals and teams. Staff, service users and carers need to recognise that each play a vital role in the wellbeing of the person needing our help and the power imbalance between the three parties needs to be acknowledged and addressed. Genuine coproduction will mean that people’s cultural needs will be met because their assets, needs and wants will be at the heart of what we develop to support them when they have mental health difficulties.

We will work collaboratively with our local partners to provide joined up care, close to home and focus on key outcomes that matter to local people. We will focus on prevention, access, early intervention and recovery to improve our reach and positive improvement for people's lives. To drive primary prevention, we will work with a wide range of partners - schools, the policy, local government and housing – developing and sharing the evidence about what works and helping educate people about mental health. Embracing partnership working and forging local connections, relationships and partnerships will help develop a collaborative movement to improve life opportunities. This will build on our existing work in Lambeth where resources have been pooled to prevent long in-patient stays for patients and for older adults in Croydon.

**Our initiatives**

**Working in partnership with people who use services, their friends, families and carers and members of local communities:**

- Improve the number of service users and carers that we can demonstrate we are working collaboratively with in planning their own care.
- Improve the accessibility of information on our support and treatments options to help people to make choices.
- Embed the Carers Engagement and Support Plans across all operational directorates to ensure carers are identified (recognising that some services have minimal contact with carers e.g. IAPT).
- Training and development for staff, service users and carers to improve confidence and knowledge in increasing partnership working with service users and carers, recognising their assets and meeting all their cultural and other needs.
- Impact on individual service users and carers to be looked at to better understand what has been helpful and what could make the experience better.
Embed partnership working in all aspects of the quality improvement programme - service users and carers to be involved from concept.

Demonstrate the positive impact of involving people in the delivery and governance of services. Feedback to be given over time about tangible and improved results as a consequence of partnership working.

Continue to develop the successful Recovery College to provide courses and workshops that are developed and delivered by service users, carers and SLaM staff.

Continue to support the vibrant and active Volunteering Service, funded through a partnership between the Trust and the Maudsley Charity. A new young persons volunteering service has been recently established.

Grow our vibrant Involvement Register - a register of people who use services, and their friends, families and carers, who have signed up to undertake involvement opportunities in the Trust. These opportunities include attending meetings, such as Service User and Carer Advisory Groups, Link working, delivering training, participating on interview panels or commenting on Trust policies and strategies. Each month around 50 different types of involvement opportunities are undertaken by around 60 people. The Register currently has 241 active service users and carers signed up to it.

Be an active partner within the Black Thrive initiative seeking to deliver system-wide changes to the health services and improve the wellbeing of Black communities in Lambeth and other similar models as they develop in each Borough.

Support the work of the Borough-based Joint Working Groups with the local Independent Advisory Groups to help improve the trust and confidence of the local Black African and Caribbean and other local communities in mental health services.

Build on strong service user partnership working at local levels (e.g. Service User and Carer Advisory Groups) and our trust-wide committees.

- Service User Involvement Committee, (coproduced and co-chaired by service users and staff) to provide the strategic voice for service users to ensure that the issues that are important to service users are raised, discussed and acted upon, feeding into the Quality committee of the Trust Board.
- Family and Carers Committee (coproduced and co-chaired by carers and staff) to focus on the experience of friends, families and carers feeding into the Quality committee of the Trust Board.

**Partnerships to help local communities realise their potential:**

- Play an active role in system leadership roles - within our two STPs, offer significant leadership e.g. chairing workstreams around mental health, clinical programmes, estates and productivity and playing an active role in Health and Wellbeing Boards and pan-London initiatives such as Thrive LDN and Healthy London Partnership.

- Develop our new operating structure that is focused on delivering care within our London boroughs by supporting closer working with our local partners around the needs of local people and responding to commissioning changes within our boroughs.

- Develop and deliver new local delivery models and move to whole-population contracts in all our boroughs, based on better population outcomes starting with the Lambeth Living Well Network Alliance and kicking off discussions in Southwark and Lewisham. Lambeth has one of the highest prevalence of serious mental health illness in England. To meet the challenges and transform mental health services, Lambeth is delivering care and treatment to working age adults through an alliance contract which is underpinned by a bio-psycho-social model.
Improving mental health services in Lambeth one step at a time – pooling budgets and services in the Lambeth Living Well Network Alliance

The aim is to join up services around the needs of those who use them; providing easier access and better services whilst also making the best use of the ‘public pound’.

*Bring services together* The Living Well Network Alliance brings together those who use services, those who plan and buy services (commissioners) and those who deliver them (providers) to design, develop and deliver a new model of adult mental health services in Lambeth. For people who use services, this will make it easier and quicker to get the service they need and reduce the merry go round of referrals from one part of the system to another. The new approach will also make better use of professionals’ time and expertise by involving the voluntary and community sector where this makes sense. Importantly, the new approach will treat those who use services as equal partners, recognising that they come with strengths and ‘assets’ and involving them in the design and development of services generally and their care in particular.

*Preventing illness* The Alliance will use this joined-up approach to focus more on preventing people getting ill in the first place and supporting them earlier when they are ill. As well as providing faster care, which is likely to mean a better result, it will also reduce the need for more expensive and less suitable hospital care. The Alliance is building on significant joint work which is already bearing fruit in the borough. For example, over 500 people each month are being supported by the Living Well Network Hub. Without this, many of these people would have had no support; some would have been left to manage alone, with the risk that they could get worse and be a risk to themselves or others or even need care in hospital.

The Alliance recognises that certain parts of Lambeth’s community, particularly black men, are often over-represented in the mental health system and that they report a worse experience of these services than others. The Alliance will do everything in its power to ensure that all sections of Lambeth’s community are treated equally and will work with those traditionally less engaged to design services that best meet their needs.

The LWN Alliance will be working towards a single set of shared outcomes. These encompass the Living Well Collaborative’s *Big Three Outcomes*, which were coproduced with service users, carers and providers. The Big Three Outcomes are for people with mental health issues to:

1. Recover and stay well, experiencing improved:
   - Quality of life
   - Physical and mental health
2. Make their own choices and achieve personal goals, experiencing increased:
   - Self-determination and autonomy
3. Participate on equal footing in daily life, specifically
   - To ‘connect’ with others e.g. family, friends & neighbours
• To ‘give’ in the community e.g. community activities, volunteering, peer support
• To ‘be included’, especially in relation to education, employment, adequate income and stable housing
• To ‘participate’ on an equal footing with others with reduced stigma and discrimination e.g. access to mainstream services, housing, education and employment

The LWN Alliance outcomes build upon these Big Three Outcomes. Additional outcomes relating to finance, style of delivery, staff and carer experience and population-based measures have been added.

○ As a leader in integrated care and population health, we will review and develop our approach, including maximising the value of data and the expertise of the IoPPN.

A joined up approach to Mind and Body and physical healthcare:

○ We are working with Guy’s and St Thomas, King’s College Hospital and King’s College London, along with Southwark and Lambeth Clinical Commissioning Groups as part of King’s Health Partners’ Mind and Body programme to embed integrated mind and body care as business-as-usual. The programme will: improve routine identification of mental health needs in physical health settings and vis versa; ensure we respond to those needs, using stratification and a stepped care approach; providing a broad programme of learning and development for all staff to improve confidence to deliver ‘mind and body’ care.
○ We want to improve the physical healthcare of our service users and staff. Our physical health strategy will guide a more effective approach to health promotion and physical health care across all clinical settings. The increase of physical health awareness training will ensure all staff meet these standards. Teaching sessions continue to take place for community and early intervention screening.

Thrive London is a citywide movement to improve mental health and wellbeing of all Londoners, supported by the Mayor of London. It is led by the London Health Board, in partnership with Greater London Authority, Healthy London Partnership, NHS England (London Region), Public Health England (London Region) and London Councils.

On 4 July 2017 Thrive LDN launched six aspirations for London, and a number of actions Thrive LDN and partners will take over the next year, these are:

• A city where individuals and communities take the lead
• A city free from mental health stigma and discrimination
• A city that maximises the potential of children and young people
• A city with a happy, healthy and productive workforce
• A city with service that are there when, and where needed
• A zero suicide city
A great place to work: we will value, support and develop our managers and staff

Our ambitions

The quality of care that service users receive depends first and foremost on the skill and dedication of our staff. We know that staff who are engaged, happy and supported at work provide the best care. Our passionate staff do a difficult job, often in challenging circumstances and there is more we can do to improve their experience, satisfaction and joy at work and equip them to deliver quality care. This will come from listening to their views and valuing their contribution as well as offering opportunities to develop new skills and career progression as part of their continuous development, and investing in staff wellbeing. Making the trust a great place to work will help us continue to attract and retain the very best people.

Our initiatives:

- **A new recruitment and retention strategy** with increased investment: improving the recruitment pathway, investment in staff counselling, guaranteeing employment to students as they qualify.
- **Step change in training, education and development opportunities** in line with expectations of better training and education than most other trusts. We will reassess our training and development offer. Individual, co-leadership and team coaching to help individuals to put new skills and leadership behaviors into practice. Investment in quality improvement as an organisational development approach to create a learning organisation.
- **Leadership development and organisational development**: including investment in our inclusive Leadership programme to involve every manager across the whole organisation.
- **A comprehensive nursing development programme** to support the retention, development and recruitment of nursing staff: including the introduction of nursing associate/assistant practitioner roles to create more skilled and stable nursing teams.
- **Health and well-being**: a more comprehensive strategy recognising pressures on workforce and drawing together existing initiatives such as the physical care strategy and providing confidential psychological support for staff who are experiencing difficulties at work or home.
- **Develop our Freedom to Speak Up structure**, the importance of which is reflected in the fact that it is led by the Chair and CEO.
- **Improve change management**: assess and act on leadership development and organisational development needs. Visible leadership across the organisation: NEDs regularly visit services and SMT members Quality Improvement (QI) visits.
- **Develop and deliver equalities strategy**: an Equalities and Workforce Committee of the Board to strengthen governance on equality, diversity and inclusion. A focus on BME staff experience: led by the BME Staff Network, the Trust Board has clear targets and interventions in place around career development, progression, representation at senior grades and also representation in disciplinary processes. Other networks are also actively supported, including LEN, LGBTQ and administrators.
- **Staff communications**: regular and dynamic approaches; new intranet; introduce new team briefing arrangements.
- **Staff recognition** with more engaging staff celebrations: annual Staff Awards, SLaM stars, eNews and twitter.

Innovation: striving to be at the forefront of what is possible, exploiting our uniques strengths in research and development, with everyone involved and learning
Our ambitions

We will maximise how service users and the local community benefit from research and development by making it a routine, core part of clinical activities across the organisation - in all professional groups and more teams across our geography. This will build on our unique breadth and depth of research and clinical care with many clinical areas already having strong research programmes informing local, national and international practice. Leading edge big data and digital approaches will allow us to identify people at risk, identify issues and develop new interventions and deliver support and improve care.

We will answer key questions in clinical practice and population health, informing our work in the trust and that of mental health practitioners across the globe. Ground-breaking discoveries will be made and new practices introduced, refined and evaluated through our extensive clinical academic partnerships to establish evidence-based practice. Our care pathways will be underpinned by research and evidence supporting the highest possible standards of care. We will increase the number of SLaM staff involved in research by encouraging and supporting all staff to get involved and take more active roles in leading research and take pride in being part of a research active organisation.

Quality improvement approaches will be used to put evidence-based practice into wider use and to become a true learning organisation and system. Our approach to education and training will support staff to get involved in both research and quality improvement which will help to further develop an ethos of innovation as we develop our workforce and our clinical services.

The Maudsley Charity is one of the larger hospital charities and able to make a significant difference to innovation in the trust. It works closely with our staff to generate ideas that will make a difference to care, treatment and service innovation.

As a trust, our relationship with academic mental health and the world leading reputation of the Maudsley brand in research and innovation is perhaps what we are most known for. As such leaders for mental health, we will use the insight and our voice to improve care nationally and internationally and tackle stigma and discrimination.

Our initiatives

Our R&D strategy supports active research and the translation of evidence and research into clinical practice and population health—making it real and valuable to staff and service users:

- **A rich and diverse portfolio** Our Clinical Academic Groups (CAGs) provide strategic leadership: They will identify teams where there is scope to increase research activity and unanswered clinical and service questions that research could inform. Some of these will be identified through the quality improvement loop. They will also develop strategic work plans on the delivery of evidence and the latest research findings into practice.

- **Service users and carer involvement** We will make service users and carers aware of opportunities to participate in research and provide reassurance that it is high quality, safe and ethical. They will shape research by being involved in research at every level, including the R&D management processes.

- **Supporting staff to be research active – new support, training opportunities and funding** We will continue to listen to staff about the support they would welcome. Working with the IoPPN, including in the context of the BRC and CLAHRC, we will access state-of-the-art facilities, honorary academic titles, mentoring and career development. Our CAGs will promote research as part of every professional’s remit and we will support and guide our staff in their research endeavours and steer individuals towards appropriate research training options. We will develop a menu of research training opportunities for all professional groups to build skills, increase the number of SLaM staff with research identified as part of job plan, develop research career pathways for clinicians and increase the number of SLaM Principal Investigators. We will create new posts to help staff secure research grants and create a strategic research capability fund to direct towards clinical teams, to support new research hotspots and grow existing research activity.

- **Recruitment of research participants** Our CAGs will encourage researchers to recruit through SLaM, in particular to develop interventional studies and engage with clinical teams to increase their recruitment of participants, especially into NIHR Portfolio projects (including those led by other centres) and into
commercial studies. We will create fixed-term sessions for clinicians to lead on this. Staff will be encouraged to sign up patients to Consent for Contact (C4C) and researchers will be encouraged to use C4C to recruit patients.

- **Highest scientific and ethical standards** We will continue our effective research governance and management, led by the joint R&D Office of SLaM and IoPPN.
- **Research communication** We will work collaboratively with our close partners across KHP, particularly the IoPPN and with the CLAHRC (based at King’s College Hospital) and Academic Health Science Network (Health Innovation Network) to ensure that stakeholders are aware of the trust’s research findings and innovative approaches.
- **Shape national best practice guidance** through the involvement of our leading clinicians and academics.

Develop the SLaM-IoPPN Centre for Translational Informatics to deliver excellence in the use of informatics/big data for population based prediction, understanding of risks and causes, and the development and testing of digital innovations. The Centre will take advantage of the new opportunities from the vast amounts of data being generated, enable rapid translation of digital research developments into validated clinical practice tools, including novel mobile health and remote sensing technology and ensure we develop approaches that are scalable and transformative.

Attract funding based on our world leading researchers, educators and clinicians to create a new Centre for Young People’s Mental Health. This will support young people locally, nationally and globally through integrated clinical services, research and education and outreach. The centre will pioneer research, establish the best care and advance training to deliver world class outcomes for mental health. It will be unique in scale of ambition, the collaboration and in the widely-recognised international excellence of the founding partners.

Develop our education and training strategy in support of our quality agenda, sharing of best practice and advocacy of mental health:

- Our education and training plans (described in ‘A great place to work’) will support a culture change to focus on consistent delivery of the fundamentals of care and continuous improvement.
- Launch Maudsley Learning to make a step change in our work as a lead provider of education and training, building on our education and training directorate and Maudsley Simulation. Maudsley Learning will produce and deliver the highest quality, internationally renowned education and training products in the field of mental health and wellbeing. We will educate and train, traditionally and digitally, at scale to range of professional groups globally. We will offer a full range of education and training products from e-learning and other digital products, through face to face classroom teaching to more immersive and experiential simulation and skills based courses. These will be developed by harnessing the world leading subject matter expertise and cutting-edge thought within the trust and IoPPN. Our curriculum will address the educational requirements of a range of professionals involved in healthcare and associated organisations as high quality CPD & HEI micro-accredited courses. Institutions will be able to purchase on behalf of their staff to enable higher quality and safer services through workforce development and inter-professional learning and individuals in healthcare and beyond wishing to enhance and advance their own careers will be able to purchase courses tailored to their own professional development. This will share our learning, commercialise our know-how and intellectual property and generate funding for the trust’s services.

Common purpose:

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

Priority areas for research

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

**Our ambitions**

We will ensure our care services and support services provide the best possible value by focusing on the outcomes we achieve for the resources. Being financially sustainable and governed to the highest possible standards is a core focus with a strong interface between performance, finance and quality. We will manage our costs effectively so we can re-invest in our people, innovation, research and training. Reducing clinical variation will provide better value. Commercial ventures will allow us to reinvest in staff development, innovation and local services at a time when these budgets are under pressure. Staff will be able to make the best use of information with reliable IT infrastructure and applications and data to support quality improvement and innovation. Our staff and service users will benefit from being in places we are proud of.

**Our initiatives**

*Continue to develop our leadership and governance:* invest time and energy into board development and develop a plan to close the gap against best practice in governance building on our clear structure of Board Committees and strong relationship with the Council of Governors (CoG). Develop My Team dashboard and development of BI, ARC and Trust dashboards.

*Take forward our 5-year financial strategy* which is based on a trust-wide assessment of the base financial risks and opportunities over the next 5 to 10 years and captured in our Long Term Financial Model. This dynamic model allows the Trust to understand the long-term financial impact of key strategic decisions and model new scenarios. The strategy will allow us to meet our £2.5 million surplus requirements, maintain suitable cash and liquidity and afford investment in key areas i.e. innovation, development of our workforce and estates.

*Commercial development:* Take forward commercial opportunities, in line with the organisation’s vision, that will enable us to further support and invest in our local services by delivering an equivalent of 1% of turnover as an initial target. We will:

- ensure commercial continues to work effectively in core areas and services
- increase estates commercial activity
- grow ventures in international growth we have been progressing our international plans – most notably in the UAE for circa 5 years (3 years in operation in a joint venture between the trust and Macani Medical Centre, an Abu Dhabi-based organisation set up to bring the highest quality health care to the Middle East and North Africa (MENA) region) and are exploring training and research ventures (jointly with KCL/IOPPN) in China.
- grow ventures in commercial education and training - Maudsley Learning.
- consider private healthcare
- pursue digital opportunities, usually in partnership

To support this we will better manage our brand and Intellectual property, develop commercial awareness, skills and capabilities within the commercial team and more widely and, ensure strong management and governance.

*Deliver improvements to the quality of our estates and facilities* – our places and spaces must offer a safe a therapeutic environment for patients as well as being accessible to the community and inspiring places to work. An extensive development programme is being implemented across the trust with the overall aim of transforming our estate to enable 21st century mental health care. We will modernise and refurbish our
buildings and create new centres of excellence, enabling the elements of clinical practice, research, education and training to be brought together. We will reappraise our community hub strategy and move at least one integrated hub into each borough. We have two new hospital builds in train – delivery of the Douglas Bennett House scheme on the Denmark Hill site and rebuilding the National Autism Unit.

Progress on implementing our digital strategy and becoming a Global Digital Exemplar:

- Ensure the basics are securely in place (data, informatics and hardware, WiFi and connectivity) to support front line with the right digital kit to do their job as highlighted in our ‘Digital Me’ campaign.
- Triangulate data more effectively to spot variance more quickly and use locally sensitive data more effectively.
- Implement electronic observations, electronic prescribing, improvements to our electronic record and our new online personal health record, Healthlocker.
REPORT TO THE TRUST BOARD: PUBLIC
18 SEPTEMBER 2018

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Purpose of the paper
To inform the Board about significant issues affecting the Trust.

Inspection by the Care Quality Commission

1. As part of the Care Quality Commission inspection regime, the Trust was subject to a planned comprehensive inspection during the months of July and August. During July, the focus was on the front-line services and a number of services were visited including our acute inpatient wards, our crisis teams, our eating disorder services, our forensic services, our community services for older adults and more. During August, we were inspected against the ‘Well Led’ domain and this involved a number of interviews with members of the Executive team, our Non-Executive Directors as well as a number of focus groups.

2. The preparation for a CQC inspection takes a number of months and involves the sharing of a significant amount of data with the Care Quality Commission. During the inspection itself, staff across a number of teams spend time with the inspectors while they work, showing them how they carry out their roles and answering their detailed questions. We always encourage staff to see this as an opportunity to showcase the important and challenging work that they do on a day-to-day basis but we also recognise that inspections can be a stressful time for staff. I would like to extend my sincere thanks to all our staff who worked so hard during this period to support the CQC with their inspection.

3. The formal outcome of the inspection will not be known until the middle of October at the earliest, but we have already received some information from the inspectors. The informal high-level feedback suggests that there have been tangible improvements across a wide number of our services. If confirmed, this is to be celebrated because it is the product of an
extraordinary amount of hard work in a number of teams that will result in improved care for our service users.

4. However, we were also informed over the summer that the CQC would be issuing an improvement notice in relation to variability in the quality of care across our acute and crisis pathway over time. The notice is unusual in that it focuses on unwarranted variation over time and place – different problems occurring in different places at different times. For this reason, the CQC view this as a local governance issue. Information about the improvement notice has been shared with Governors and we have immediately begun a focused programme of work to agree an improvement plan to deliver the necessary improvements by the beginning of April. Rich discussions with senior leaders and their teams have resulted in the following areas being identified for improvement: Fundamental Standards of Care; Governance; Leadership and Culture; and Clinical Pathways, including flow and discharge planning. Some of these are areas of work already underway but which we will be bringing forward. In particular, our move to a borough organisation is specifically designed to address many of the issues raised. In addition we have also taken immediate action in relation to a range of areas, including ensuring consistent monitoring following rapid tranquillisation; clarity on the fundamental standards of care and borough improvements; roll-out of the e-observations tool to improve physical health care observations; changes to the ES1 garden; and continuing to drive the Multi-Agency Discharge Events with our partner organisations to rapidly improve the discharge of service users to the most appropriate setting.

5. The CQC have given us until 1 April 2019 to address the issues in the warning notice. We are confident that we will be able to make the important changes that are necessary to ensure consistent care across our acute and crisis pathway for our service users. We will keep everyone fully informed about our progress.

Annual Members Meeting and Staff Recognition Awards

6. On Tuesday 25th September, I am delighted to be hosting, with Roger Paffard, the Annual Members Meeting and Staff Recognition Awards. These events are always a fantastic celebration of the excellent work of our dedicated staff and teams, as well as an opportunity for our members to hear about the work of our Governors and ask questions about the Trust. I am very grateful to all those who have been involved in judging the panels and in helping to design what I’m sure will be an uplifting and enjoyable event. I look forward to seeing as many of you there as possible.
Our new Joint Director of People and Organisational Development

7. I am delighted to announce the appointment of Mary Foulkes OBE as our new Director of People and Organisational Development. The role will be shared between South West London and St George’s NHS Trust and SLaM. Mary is a highly experienced HR Director who has worked at senior levels for over 20 years in a range of different sectors, including manufacturing, banking, third sector and the NHS. She has also been a local councillor in Southwark, and received an OBE for her charitable work and services to diversity. I know that she will be a fantastic addition to our Board.

Dr. Matthew Patrick
Chief Executive
Planning & Strategy Working Group - 17 July

The group met on 17 July, with an extended agenda to allow time for follow-up questions from the June Council of Governors’ meeting regarding the Lambeth Alliance and partnerships more generally. Matthew Patrick introduced Governors to the plans for the Centre for Children and Young People, while Michael Holland and Barbara Grey provided an update on the Quality Improvement programme, including how the Trust’s return on investment is measured.

Visit to the Ladywell Unit – 19 July

A group of Governors joined three Non-Executive Directors on a visit to the Ladywell Unit on 19 July. Another site visit has been arranged for 11 September, this time at the Maudsley Hospital (AL3, Eileen Skellern 1 and Jim Dickson wards).

Governor / NED meeting – 24 July

The Governors met the NEDs ahead of the Board meeting on 24 July, and raised issues including progress with the Quality Improvement programme; the implementation of Seni’s Law; the provision of accommodation for staff; and developments arising from the Snowy White Peaks Working Group.

Quality Working Group - 26 July and 10 September

The group met on 26 July. The agenda focused on how lessons are learned across the Trust in terms of complaints, feedback and Serious Incidents. The Governors also used this opportunity to put a number of questions to the NED Chair of the Quality Committee, and to consider the limited assurance report on the Quality Accounts from the auditors. A smaller group of Governors met the auditors on 29 August to go through the report in more detail.

An extraordinary meeting of the Quality Working Group has been called for 10 September, designed to give Governors an opportunity to learn more – and ask questions about – Trust projects to reduce length of stay, how quality of care is maintained post-discharge, preventing re-admission and about current demand for inpatient beds.
Care Quality Commission inspection

The CQC held a focus group for the Governors on 31 July, as part of the inspection process. The Governors were informed of the warning notice on the same day.

Membership & Involvement Group – 31 July

The group met on 31 July and Sally Storey, Director of HR, attended to talk about staff wellbeing. The group also discussed the upcoming Governor elections and how candidates and new Governors may be best supported in fulfilling their role.

Bids Steering Group and Bids Assessment 2018

The Bids Steering Group met on 2 August, with a day to assess the bids submitted under the “Smile Together” scheme was held on 7 August. There were 141 bids received in total, of which 74 were successful. £47,741.70 in total has been allocated.

Council of Governors’ meeting – 13 September

The full Council meets on 13 September, and will receive the auditors’ limited assurance report on the Quality Accounts as well as the annual report from the Audit Committee. This will also be the forum for the Chair to update Governors on the recent CQC inspection and to outline the improvement plan put in place as a result of the CQC warning notice in respect of the acute pathway.

Governor elections

The election process is currently underway, with two public, three service user and two staff vacancies. Nominations close on 19 September, with the election itself taking place in October and results declared on 5 November. New Governors will take up post from 1 December.

Lobbying

A group of Governors have responded to a call from the Mental Health team at NHS England, asking for views on long-term plans for mental health.

Following a meeting between the Lead and other Governors and Helen Hayes MP (Dulwich and West Norwood), a letter to the Secretary of State has been drafted – setting out concerns regarding mental health funding – with a view to it being sent jointly from South London MPs and those Governors who wish to sign up to it.

A group of three Governors, plus stakeholder Governors from Croydon CCG and Croydon Council, met with members of Croydon CCG on 9 August. Governors are hoping to invite other CCG representatives to their next Away Day in October.

Annual Members’ Meeting

The AMM takes place on 25 September at the KIA Oval.
REPORT TO THE TRUST BOARD: PUBLIC
18 September 2018

<table>
<thead>
<tr>
<th>Title</th>
<th>Performance and Finance Report</th>
</tr>
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<tbody>
<tr>
<td>Author</td>
<td>Rod Booth, Director of Performance, Contracts and Operational Assurance</td>
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<tr>
<td>Accountable Director</td>
<td>Kristin Dominy, Chief Operating Officer Gus Heafield, Chief financial Officer</td>
</tr>
</tbody>
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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 provides an update regarding the Performance Management Framework review meetings, noting the plans to reflect the new borough delivery structure.
To report on current contractual matters arising and the 18/19 Programme Management Office plans (CIP, QIPP and CQUIN).
To report the Trust’s financial position, risks and forecast for the year.
To report on the Trust’s emergency preparedness status and current actions.

Executive Summary:
The Trust continues to meet the NHS Improvement Single Oversight Framework indicators covered by this report.
There is continuing pressure increase across the adult acute pathway (inpatient and community) resulting in sustained usage of external overspill inpatient beds.
The Programme Management Office is supporting the 18/19 oversight process for CIP, QIPP and CQUIN. £3.8 million of the CIP programme is currently rated as high risk.
There is an agreed approach with commissioners to evaluate their investment plans and the Five Year Forward View transformation trajectories.
We continue to work with both Southwark Local Authority and CCG to evaluate the impact of the proposed changes regarding section 75 and to align CAMHS services to the outcome of the recent review; the risk from the reduction in placements budget by Southwark Local Authority is being assessed and forms part of a wider programme on reviewing placement options. A number of CAMHS initiatives are to be noted.
Continued progress is evident with our emergency preparedness.

Finance Headlines
- **M5 YTD** - £0.1m adverse to plan
- However, if costs proceed at the current rates significant **forecast pressures** (£6m) will require action in order to achieve the Trust’s Control Total. Recovery plans to ensure delivery in development.
- **CIP** still expected to deliver £16.4m but slippage on Overspill will require replacement schemes.
- **Cash** position remains robust at £74m YTD.
- **Capital** spend is £3.5m YTD (£3.4m lower than plan). Strategic Estates programmes (NAU, Norbury ward, DBH, CAMHS Tier 4 & CYP) are due to commence later in the year.
- All figures stated in key drivers and risks below represent full year forecast impacts.

### Key Drivers (included in the forecast)

- **Key areas driving overspend operationally YTD are:**
  - Overspill (41% in Lambeth) - £2.7m +
  - Ward Nursing Costs – mainly Bank use - £3m run rate pressure
  - Agency usage – at a 20% premium - £3m run rate pressure

- **Key areas driving overspend corporately are:**
  - Medical - Junior Doctors Costs including agency use - £0.5m
  - Estates – ISS Contract dispute and utilities inflation - £0.6m
  - HR - training income, apprenticeship costs & payroll transfer - £0.6m
  - Reduction in R&D income - £0.35m.

### Key Risks (not included in the forecast)

- Southwark Local Authority fail to fund Complex Placements (£1.0m to £1.9m)
- SLaM unable to mitigate longer term Overspill pressure (an additional £0.0m to £3.0m)
- SLaM are unable to deliver backloaded CIP requirement (SLP & Boroughs) - £1.0m to £2.0m

### Risks / issues for escalation

BAF Risk 2: If the trust does not deliver services from an effective operational structure, have clear care pathways and clinically driven care protocols there is a risk that there will be delays in care and that transfers between services will adversely impact the quality of care and service user experience.

BAF Risk 3: Failure to develop Trust informatics systems could adversely impact the quality of care, staff experience and our ability to meet contract requirements.

BAF Risk 5: If the Trust fails to listen to the experience of people that use services there is a risk that services will not learn and not improve safety and the experience for all.

BAF Risk 6: If the Trust does not have the capacity and the commitment to work with external partners there is a risk that it would be more difficult to deliver / bid for services that meet service user need thereby undermining the sustainability of the Trust.

BAF Risk 7: In the context of significant demand and change there is a potential risk that the Trust will fail to deliver the necessary quality improvements identified by the CQC or meet our other statutory duties and therefore create a risk of breaching regulation.

BAF Risk 8: If new contract values and the transitions to new contracts do not provide sufficient financial resource to deliver high-quality clinical care there is a risk that the Trust will not be able to provide timely access to safe high-quality services across all boroughs and care pathways.

BAF Risk 10: If we do not work in a way that protects the reputation of the Trust there is a risk that we will find it difficult to recruit staff, service users will report adverse experience, we will not be an attractive business partner and we will attract undue attention of our regulators.
BAF Risk 11: There is a risk that the significant time, resource and money that the Trust has invested in quality improvement will not result in the improvements in quality and efficiency of services that is anticipated.

BAF Risk 12: If services and departments do not deliver within their budgets, do not deliver the planned cost improvements, QIPPs and CQUINs and if we do not manage the need for inpatient beds within the Trust capacity the risk is that costs are uncontrolled and that the financial position of the Trust is destabilised which prompt intervention by the Regulators

BAF Risk 13: If the Trust fails to meet its mandatory training compliance targets as a result of poor local management oversight, data quality or availability of courses, there is a risk to staff and patient safety and of breaching regulation of the local training gaps with a risk to the safety of staff and patients

Committees where this item has been considered

<table>
<thead>
<tr>
<th>Date</th>
<th>Committee / Meeting</th>
</tr>
</thead>
<tbody>
<tr>
<td>11 September 18</td>
<td>Quality Committee</td>
</tr>
</tbody>
</table>
PERFORMANCE AND FINANCE REPORT

1. Report 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 Seven Day Follow Up
   2.1.7 Improving Physical Healthcare
   2.1.8 Community QuESTT
   2.1.9 Community Wait Times

2.2 Business Intelligence and Trust Information Developments

3 Operational Performance and Activity
3.1 In-Patient Activity and Performance
   3.1.1 LSLC Admissions
   3.1.2 Delayed Transfers of Care

3.2 Community Activity & Performance
   3.2.1 Dementia Diagnosis Rates
   3.2.2 A&E Mental Health Liaison
   3.2.3 Community Teams

4. Directorate Performance Reviews Summary
4.1 Training
   4.1.1 Mandatory Training Compliance
   4.1.2 Current Compliance Rates
   4.1.3 Life Support
   4.1.4 PSTS
   4.1.5 Infection Control

5. Commissioning
5.1 Lambeth and Croydon Alliances
5.2 Ann Moss Unit / Older Adult Specialist Care
5.3 CAMHS
5.4 Commissioner-related Quality Impact Assessments (QIAs)
5.5 Commissioning Programmes 2017-18
   5.5.1 Quality, Innovation, Productivity and Prevention (QIPP) programme
   5.5.2 Commissioning for Quality and Innovation (CQUIN) Schemes

6. Programme Management Office (PMO)
6.1 Cost Improvement Programme (CIP)

7. Finance
7.1 Current Position
7.2 Financial Risks & Key Issues
7.3 Forecast
7.4 Financial Summary
7.5 Key Cost Drivers

8. Emergency Planning

9. Conclusion

Appendix 1 - Glossary
1. Report Summary
The following areas of the report contain noteworthy risks:

- NHSI indicators – 7-day Follow-up performance
- Pressure being experienced in adult acute inpatient activity
- Growth in A&E Liaison presentations
- Community activity – A&L, HTT and EI caseloads

The report confirms an agreed approach with commissioners to evaluate the national transformation expectations and the available investment funding agreed for 18/19.

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 Committee (Quality indicators). Performance for August is being validated at the time of writing.

There are no key risks identified for these indicators.

2.1 NHSI Indicators: Access, Effectiveness and Quality

2.1.1 Home Treatment Team Gatekeeping

![HTT Gatekeeping Graph]

Fig. 1 NHSI Indicators: HTT Gatekeeping.

The Trust’s performance continues to exceed the 95% target. Previous underperformance that were attributed to data recording issues, are being reviewed for amendment via patient data system.
2.1.2 Early Intervention in Psychosis 2-week standard

Fig. 2 NHSI Indicators: Early Intervention in Psychosis

The Trust continues to exceed the 53% target for 2018/19 Early Intervention waiting time standard, and fully prepared for the data submission switch from Unify system to the Mental Health Services Data Set. The service is progressing with the work of monitoring the impact of increased growth and evaluating other factors influencing team workload.

2.1.3 IAPT Waiting Times

Fig. 3 NHSI Indicators: IAPT 18 week Waiting Time Standard

The Trust continues to surpass the 18 week standard across all four boroughs in 2018/19. The Trust is judged by its regulators and NHS England based upon information produced by NHS Digital as opposed to the locally reported information. NHS Digital targets are represented by the green line in the chart, the most recent data being May 2018. Local figures (in blue) are a snapshot of the live system and there will always be minor variation due to rounding practices used by NHS Digital. Another source of variation is late data entry and changes to data by clinical services – these
additional charts have highlighted areas where this could be addressed with the intention of assisting teams to reduce this source of variation. This additional cross-monitoring will continue to be reported.

**Fig. 4 NHSI Indicators: IAPT 6 week Waiting Time Standard – aggregate and detail**

Trust’s aggregate achievement for the 6 week standard remains high at 89%, with varying achievements across the four boroughs. The individual borough performance is reported in Fig. 4, alongside the equivalent NHS Digital published data (red line) for each borough through to May.
We have an agreed action plan with the Croydon CCG to increase access, including a borough wide flyer campaign and expect to meet access targets by March 2019. Southwark have been removed from the IAPT risk register. Published figures for June 2018 are 50% recovery. Assessment processes have now been changed to improve on the dropout rate. Lewisham met targets for July with a marginal shortfall in the numbers entering treatment at 512 patients against target of 529. The increased access this month should exceed the target for Q2. The waiting time targets are now being met compared to last year.

2.1.4 IAPT Recovery

![IAPT Recovery Rate Chart]

![Croydon Local vs Published data]

![Lambeth Local vs Published data]

![Lewisham Local vs Published data]

![Southwark Local vs Published data]

Fig. 5 NHSI Indicators: IAPT Recovery Rate – aggregate and detail
The IAPT recovery rate is marginally below the 50% target at 48.17% in July 2018. Croydon, Lambeth and Southwark services are performing above the 50% target rate at 55%, 53% and 51% respectively; with Lewisham performance below target at 47%.

### 2.1.5 IAPT Payment By Results

Following the Trust’s recent restructure to Boroughs, IAPT services have been delineated by borough. There has been no further progress following the national initiative to change the payment mechanism for IAPT services from 100% block and SLaM’s proposal in agreement with commissioners, for a pilot process with minimal changes. The national tool that automatically calculates outputs from local data is still being developed and the plan is to pilot in a borough as soon as it reaches a testing phase.

### 2.1.6 Seven Day Follow Up

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

**Fig. 6 NHSI Quality Account Indicator: Seven Day Follow Up**

Following the escalation of the underperformance recorded between March and May to all Service Directors, Seven Day Follow Up was reviewed across all community teams as well as through data assurance processes. Performance for subsequent months, June and July, has improved remarkably above target, following these interventions.

Whilst Seven Day Follow Up is no longer a national target in the SOF, it remains a mandated component of the 2016/17 and 2017/18 Quality Account. Given the importance of the measure, it continues 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.

### 2.1.8 Community QuESTT

The pilot Community QuESTT was introduced in the December 2017 Board Report. The intention is to provide insight into the pressures and risks in community teams using automatically reported
data, similar to the inpatient QuESTT (which is reported using a manual return). The inpatient parameters are being reviewed and adapted to the community services context to ensure relevance.

The development continues to use QI principles and will continue to test the usefulness of the tool for the MHOAD memory and community teams before rolling out to a broader audience. This also aligns to the on-going work around reconciliation of workforce data which underpins several of the proposed measures in the community QuESTT.

Examples of the current drafts dashboards are displayed as Appendix 2, although these will change as the development takes place. Feedback will be gathered at the beginning of September which will help shape the overall dashboard strategy. The Community QuESTT dashboard will be aligned and most likely integrated with the Deming Trust Dashboard.

2.1.9 Community Wait Times
Community wait times were presented to the Quality Committee in April, reporting on the amount of time that service users had to wait for their first face-to-face contact with services following referral, and the number of service users still waiting after 12 months. The highest level of waits over 12 months remains the Lewisham CAMHS at 254 patients, Croydon Personality Disorders and Psychological Therapies persists at 152 patients, and Southwark Psychological Therapies has reduced marginally from 184 patients to 131 patients.

![Fig 7. Patients waiting over 12 months](image)

It has been agreed that a deep dive will be undertaken in these areas and preliminary work has started.

Lewisham CAMHS have undertaken an initial assessment locally of the patients waiting over 52 week which indicated up to 80% may be data recording issues. The remaining 20% are being more carefully reviewed and decisions being made to either correct the data recording or arrange appropriate actions. This exercise will set the standard for managing any waits over 12 months across CAMHS and then the threshold will reduce in stages below 52 weeks.

Croydon Personality Disorders and Psychological Therapies have waits of between 51 weeks and 140 weeks for the different interventions they offer, and they will review whether 152 patients is an accurate reflection of those waiting more than 12 months. 12 patients have been offered appointments and a further 7 are about to receive appointments which should significantly reduce the numbers waiting.

Although the Southwark Psychological Therapies service has seen a reduction in their numbers from 184 to 132 patients, the high figure has been recognised by the new Borough Director and is being addressed as one of her priorities for the new directorate.
2.2 Business Intelligence and Trust Information Developments

The Trust Dashboard (Deming) had its soft launch, as planned, in July, including indicators drawn from different information domains, including: activity, workforce, patient experience and finance. This positive initiative is a direct result of integrated working with the Quality Improvement team and the leadership of the Chief Clinical Information Officer. The full launch will be linked to the new intranet home page at the end of August. This is the first such launch and our learning will cover both the dashboard and also how we will roll out future information.

August and September are critical months in the journey towards improved data processes and usage overall:

- BI is redesigning the architecture of the data warehouse and the cube it feeds. The current design allowed reports to be developed relatively swiftly, but is then not sufficiently flexible for the evolution; once the information begins to be used (often with requests for additional detail). We have noticed this more in recent months as we have developed more reports fed from multiple sources. The new design will overcome these constraints and also improve the frequency of data available to community teams to support improvement initiatives.
- An additional complication in our current information process is that a number of reports come from the Biomedical Research Centre (BRC), namely outcomes and physical health. The physical health reporting uses the natural language processing (NLP) tools and algorithms, which are an area of expertise for the BRC and will need to remain. However, potentially the position with Trust outcomes could be improved if the data flows direct to BI rather than via BRC – a decision will be made in October as this will need to be added in to the new cube designs.
- Review of documentation processes supporting BI – definitions (both operational and technical), assurance processes and usage. In addition to the specific documentation for each KPI / report, a more generic training document is being produced to explain why and how we use data for planning, monitoring and improving services.

The high level six month plan covering July – January is set out below. The priority developments (Community QuESTT, PACMAN framework and the feedback from the Deming roll out) will be managed in conjunction with the data warehouse / cube redesign and documentation development. MHSDS actions and submissions continue as required.
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.

The charts show LSLC performance on a monthly basis from April 2017 to July 2018 with the contract trajectory included through to March 2019, aiming at reaching 85% occupancy. It can be seen that the contracted level of activity was revised upwards in October / November 2017 as part of the contract refresh negotiations with Lambeth and Lewisham. 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 overspills.

To support comparison, the y-axis scale for the four individual CCG charts has the same range (50 – 110 equivalent beds per month). The pressure in all systems is evident, particularly Croydon.
There is persistent cost pressure to the Trust due to External overspill. The Southwark MADE event was successfully held in July and Croydon is booked to take place on 11 and 19 September.
Southwark event reviewed 24 patients with a length of stay (LOS) of over 50 days and a combined LOS of 2404 days. 7 of the cohort have been discharged since the event and Southwark now has 21 patients with an LOS over 50 days and a combined LOS of 1980 days, so the event has had a net difference of 3 long stay patients and 424 occupied bed days, in a system that normally experiences very little movement in this category. There are also several actions still underway to discharge the remaining patients who have complex and enduring barriers that will take some time to resolve. The Southwark event also reviewed 23 patients with an EDD within 2 weeks of the event 22 of which have been successfully discharged.

Many lessons were learned from Southwark that will be taken forward into the Croydon event where it is anticipated that 48 patients will be reviewed with an LOS of over 50 days and 20 with an EDD within 2 weeks. The combined LOS for the Croydon patient cohort is 12,103 days or 33 years, so it is anticipated that many long term issues will be exposed and require resolution.

The following chart shows the overall position from April 2017- July 2018 and the increased, ongoing pressure is evident. The colours represent the split between Acute (green) and PICU (grey) beds.

![Fig. 9 – External Overspill, July 2017 through to end of July 2018](image)

A number of initiatives under the Improving Care and Outcomes (I-care) scheme are being piloted across the Trust with work identified from the recent CQC inspection being brought into this to avoid duplication:

- Patient Flow - Testing Red2Green (R2G) bed days on one ward within Croydon and engaging the other three wards at the same time. While this is teaching a process there is a cultural shift behind this work that is needed. Anecdotally it is clear that delays and barriers are being chased and acted upon more proactively.

What is R2G? “Sometimes patients spend days in hospitals that do not directly contribute towards their discharge. Through collecting and reporting ward-level data, this tool supports wards to reduce the number of ‘red days’ in favour of value-adding ‘green days’. Discharge coordination form is being redesigned and tested within ward and community teams.
- **Violence & Aggression** – data shows a reduction in incidents over the last few weeks for a number of acute wards. The QI team and modern matrons are supporting all adult acute wards with 4 steps to safety.

- **Care Process Model (CPM)** – reducing variation in practice and standards. Community CPM is being designed at the moment and will be tested first within Southwark. The inpatient CPM is due to be tested on one ward in Lewisham in September and then rolled out within that borough. There are plans underway to support and facilitate this.

**Length of Stay: Acute Care Pathway**

![Figure 10 – Length of Stay Breakdown](image)

Figure 10 clusters the inpatient cohort within the acute care pathway (wk3, August) by their length of stay at that point. The first colour is 0-30 days, then 31-60 days etc. and the final group is >180 days. The commissioners are in alphabetical order: Croydon, Lambeth, Lewisham, Southwark and “other”.

Patients with longer lengths of stay are reviewed weekly at clinical meetings. Longer lengths of stay can be attributed to delayed transfers of care, other reasons of social need and patient acuity. Lambeth CCG still has the highest number of inpatients whilst both Lambeth and Croydon continue to have a high proportion of patients with longer lengths of stay.

**3.1.1 LSLC Admissions**

The following charts show the admissions by CCG for each month Apr 17 – July 18 with planned levels through to March 2019. The planned level was based on historical performance in 2016 and was set at a flat, consistent rate. Actual performance of admission levels remained broadly consistent with a marginal fall in July 2018.
3.1.2 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 July, the Trust recorded 451 bed days lost due to delayed transfers of care. This represents a 2.1% loss, which is below the 3.5% target set from September 2017 by NHSE. The newly developed DToC process that ensures consistency in the process for agreeing and recording DToCs across the Trust is progressing along with the existing weekly DTOCs calls.

The Southwark MADE event was successful, highlighting many lessons learned that will be taken forward into the Croydon event in September. It is anticipated that many long term issues will be exposed and require resolution.
Fig. 13 – Delayed Transfers of Care, Lost Bed Days by Local Authority

Figure 13 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 the next section outlines an approach being developed to capture and report on this pressure routinely.

3.2.1 Dementia Diagnosis Rates
The national ambition is for a dementia diagnosis rate of 67% with London diagnosis rate currently exceeding the target at 70.8% in July, with achievements varying between 59.6% to 92.4%. The diagnosis rates for Trust’s four boroughs are:

- Lambeth 76.2%
- Southwark 68.2%
- Lewisham 75.5%
- Croydon 67.7%

Progress on diagnosis rates is slow partly due to multifactorial nature of this issue, need for multi-agency work and crucially, lack of consistent GP interest and engagement (with some notable exceptions of course).

Croydon - main issue is missed diagnosis in care homes. Trust has been invited to attend Care Home model of care group led by the Alliance. GPs need to make the diagnosis. There are ongoing difficulties with GP engagement in this borough (there is no GP lead for dementia) makes this hard. Trust lead has met with the new commissioner and advised on how to achieve the diagnosis rate by addressing the deficits in care home diagnosis and giving the necessary materials/references/resources. It is hoped that this will influence the Alliance to consider this issue more seriously. On positive note, the Trust has new funding for Memory Service and opportunities to recruit new consultant and practitioners which will help to improve links with primary care. Wait times are falling slowly (down to 10 weeks now) but still too high. The Memory Service QI project will be addressing this.
Lambeth - overall are doing well at the rate of 76.2 (4th in London) but could do better. Memory Service QI project led by the Quality Centre to review care pathway will help improve SLAM's care pathway. Progress with BME project is disappointingly slow, a lot of talk has happened with various community groups. Staff have been identified who will be working directly with faith groups and schools which should be a more fruitful approach (and is evidence-based). The Older adult lead has helped guide this project in a more useful direction.

Southwark CCG have not completed actions agreed at last meeting – Trust is still awaiting data harmonisation and work to carry out list of people with diagnosis in care homes. It is unclear why rates have gone down but could be attributed to data fault.

Lewisham - Previous commissioner was very engaged and started work on care home diagnosis which is very low in Lewisham. The new commissioner is equally committed however, there are issues with GP interest and engagement in the care home work. The GP Lead is very good and supportive to GP colleagues and data harmonisation is in progress.

Trust leads attended a useful meeting with CCG representatives from the 4 boroughs led by Lambeth and there was a good sense that more collaborative work needs to happen to support primary care to provide better care for people with dementia; this is the thrust of the latest NICE guidance, but may take some time. In the meantime, Trust leads are very focussed on getting Memory Services to perform at an optimum level and the new ambitious QI project and the QI team to help empower the teams and support them to share ideas and work together to reduce unwarranted variation in wait times and care delivery.

3.2.2 A&E Mental Health Liaison
The number of presentations to A&E Mental Health Liaison teams remains consistently above plan across board but particularly for Lambeth and Southwark teams. The impact of Core 24 investment and also the CQUIN work to identify very frequent users will need to be incorporated into a refresh of activity plans for 18/19.
Fig. 14 Mental Health Liaison Team Presentations
3.2.3 Community Teams
The community redesign is taking place as part of the new delivery models in boroughs. These monthly snapshots of teams will continue to be provided in this report.

The following graphs show the position at July highlighting sustained growth in the caseload size of our Home Treatment and marginal increase in that of the Early Intervention teams. The updated information to July 2018 is shown in Figs. 15 and 16.
4. Directorate 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 update and design work to the Performance Management Framework to reflect the change to a borough delivery model is undergoing further modification following feedback from the June pilot at the PACMAN meetings. This redesign will create strong alignment between the Trust’s dashboard and the Community QuESTT reports.

An interim borough-based report was developed to support PACMAN meetings in July and through Q2. During this period, the development of the new performance report (in Power BI) will continue to be tested with the intention to complete the redesign and transfer reporting over at the end of Q2.

At the August meetings (reviewing July performance), the key issues and associated actions remain consistent:
- Adult inpatient pathway pressures; external overspill and Delayed Transfers of Care (DToC)
- Placements (Southwark and Lewisham)
- Early Intervention delivery
- 18/19 CIP and QIPP schemes
- Agency expenditure and achieving the NHSI reduction trajectory
- Mandatory training compliance
- Community waiting times

4.1 Training

4.1.1 Mandatory Training Compliance
Following strenuous efforts over a sustained period the Trust has seen in a steady improvement over the past year in mandatory training compliance, and overall compliance has now reached our target of 85%. The Trust is still not where it needs to be in terms of compliance in all subjects, however, and some key subjects remain a challenge. These include life support, PSTS, and infection control, and specific action plans are in place which are already addressing each of these.

Causes of low compliance, impacts and actions plans were presented at the July Quality Committee.

4.1.2 Current Compliance Rates
Current compliance by directorate and by subject matter are shown in the tables below. The trend over the past six months is shown by subject. The trend by directorate is not available because of the shift to boroughs from CAGs.

<table>
<thead>
<tr>
<th>Directorate</th>
<th>2 July 2018</th>
</tr>
</thead>
<tbody>
<tr>
<td>Child &amp; Adolescent Services</td>
<td>82.15%</td>
</tr>
<tr>
<td>Corporate Directorate</td>
<td>83.93%</td>
</tr>
<tr>
<td>Lambeth Directorate</td>
<td>87.22%</td>
</tr>
<tr>
<td>Croydon Directorate</td>
<td>88.90%</td>
</tr>
<tr>
<td>Southwark Directorate</td>
<td>85.54%</td>
</tr>
</tbody>
</table>
PMOA
Lewisham Directorate
Clinical Support Services
Grand Total

Fig. 17 Mandatory training compliance rate by directorate

<table>
<thead>
<tr>
<th>Core Subjects</th>
<th>Dec 2017</th>
<th>March 2018</th>
<th>2 July 2018</th>
</tr>
</thead>
<tbody>
<tr>
<td>Basic Life Support - Group 1</td>
<td>91.82%</td>
<td>90.07%</td>
<td>92.93%</td>
</tr>
<tr>
<td>Basic Life Support – Group 2</td>
<td>70.32%</td>
<td>66.57%</td>
<td>76.59%</td>
</tr>
<tr>
<td>Equality, Diversity and Human Rights</td>
<td>87.11%</td>
<td>85.91%</td>
<td>91.33%</td>
</tr>
<tr>
<td>Fire Safety Awareness</td>
<td>79.79%</td>
<td>80.07%</td>
<td>84.90%</td>
</tr>
<tr>
<td>Health, Safety and Welfare</td>
<td>84.44%</td>
<td>84.53%</td>
<td>90.04%</td>
</tr>
<tr>
<td>Immediate Life Support</td>
<td>62.10%</td>
<td>70.55%</td>
<td>77.45%</td>
</tr>
<tr>
<td>Infection Control Level 1</td>
<td>90.31%</td>
<td>89.01%</td>
<td>92.63%</td>
</tr>
<tr>
<td>Infection Control Level 2</td>
<td>57.08%</td>
<td>67.34%</td>
<td>76.04%</td>
</tr>
<tr>
<td>Information Governance</td>
<td>79.69%</td>
<td>77.74%</td>
<td>81.33%</td>
</tr>
<tr>
<td>Moving and Handling - Loads - Group 1</td>
<td>86.71%</td>
<td>92.75%</td>
<td>88.97%</td>
</tr>
<tr>
<td>Moving and Handling - Loads - Group 2</td>
<td>88.46%</td>
<td>84.62%</td>
<td>96.30%</td>
</tr>
<tr>
<td>Moving and Handling - Loads - Group 3</td>
<td>86.69%</td>
<td>86.26%</td>
<td>91.09%</td>
</tr>
<tr>
<td>Moving and Handling - Patients - Group 1</td>
<td>89.31%</td>
<td>82.58%</td>
<td>79.53%</td>
</tr>
<tr>
<td>Moving and Handling - Patients - Group 2</td>
<td>82.50%</td>
<td>84.44%</td>
<td>88.87%</td>
</tr>
<tr>
<td>Moving and Handling - Patients - Group 3</td>
<td>81.40%</td>
<td>78.57%</td>
<td>92.11%</td>
</tr>
<tr>
<td>Prevent Awareness</td>
<td>86.51%</td>
<td>88.64%</td>
<td>92.75%</td>
</tr>
<tr>
<td>Prevent Workshop</td>
<td>76.01%</td>
<td>84.39%</td>
<td>89.06%</td>
</tr>
<tr>
<td>PSTS Awareness/Conflict Resolution</td>
<td>78.88%</td>
<td>78.04%</td>
<td>84.28%</td>
</tr>
<tr>
<td>PSTS Disengagement</td>
<td>64.33%</td>
<td>67.04%</td>
<td>73.17%</td>
</tr>
<tr>
<td>PSTS Team Work</td>
<td>80.07%</td>
<td>83.12%</td>
<td>86.47%</td>
</tr>
<tr>
<td>Safeguarding Adults Alerters</td>
<td>85.91%</td>
<td>84.77%</td>
<td>89.82%</td>
</tr>
<tr>
<td>Safeguarding Adults Alerters Plus</td>
<td>85.27%</td>
<td>84.25%</td>
<td>88.42%</td>
</tr>
<tr>
<td>Safeguarding Children Level 1</td>
<td>88.23%</td>
<td>87.25%</td>
<td>91.28%</td>
</tr>
<tr>
<td>Safeguarding Children Level 1 and 2</td>
<td>93.89%</td>
<td>93.67%</td>
<td>97.01%</td>
</tr>
<tr>
<td>Safeguarding Children Level 3</td>
<td>77.27%</td>
<td>77.89%</td>
<td>87.15%</td>
</tr>
<tr>
<td>Grand Total</td>
<td>79.68%</td>
<td>81.16%</td>
<td>85.83%</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Non-core – Mental Health Specific Subjects</th>
<th>Dec 2017</th>
<th>March 2018</th>
<th>2 July 2018</th>
</tr>
</thead>
<tbody>
<tr>
<td>Deprivation of Liberty Safeguards (DoLS)</td>
<td>85.66%</td>
<td>89.00%</td>
<td>88.45%</td>
</tr>
<tr>
<td>Mental Capacity Act (MCA)</td>
<td>82.60%</td>
<td>84.94%</td>
<td>89.22%</td>
</tr>
<tr>
<td>Mental Health Act Training</td>
<td>81.64%</td>
<td>84.02%</td>
<td>87.47%</td>
</tr>
</tbody>
</table>

Fig. 18 Mandatory training compliance rates by subjects

4.1.3 Life Support
Additional BLS (Basic Life Support) courses have been put on to improve compliance. Multiple dates are available for ILS (Immediate Life Support) from late July and the Education department will be piloting a half-day refresher course following a retender for our external provider as well as
training more SLaM staff to co-deliver the training. Not all courses are running at full capacity, however, and DNA rates are increasing, which represents poor use of resources. This is being picked up in performance meetings. Staff are being sent additional emails, copied to their manager, to encourage bookings.

4.1.4 PSTS
The numbers of staff requiring PSTS training has increased following a change in practice to enforce the requirement that all clinical staff working in in-patient services require full PSTS training. From July 2018 we will be moving PSTS disengagement training to the Ortus Training Centre, to use their larger training rooms to enable a greater number of delegate spaces to be offered. PSTS disengagement training is also currently being run on a Saturday to offer more options for staff. Plans are in progress to streamline PSTS training and deliver it differently and over a shorter period.

4.1.5 Infection Control
The content of the Infection Control e-learning package is currently under review by the Nursing Directorate. Staff completions are tracked, as with all mandatory training, through appraisal and local performance meetings.

5. Commissioning
All QIPP and investment schemes are now being managed using the Programme Management Office (PMO) principles. Service Development and Improvement Plans (SDiPs) have been drawn up and shared with each commissioner setting out the borough status for Five Year Forward View transformation initiatives and cross-referencing current performance, investment, challenges and change plans. Engagement from commissioners has been variable although over time the SDIP process should become embedded as it is the only way to ensure disinvestment and investment decisions aren’t made in isolation.

Adult acute inpatient service capacity continues to be a major discussion point given the ongoing heat in the system. Commissioners have confirmed their commitment to maintain the bed base in 2018/19 and to plan to commission at 85% bed capacity utilisation. The ICare programme to reduce length of stay (with flat admissions) continues to be a major focus in 2018 for commissioners as current plans indicate the potential for a ward closure early in 2019/20 which is based on SLaM activity trajectories and ICare plan. The current operational performance indicates that significant improvements must be achieved rapidly if the March 2019 targets are to be met.

There is on-going discussion with both Southwark Local Authority and CCG to evaluate the impact of changes regarding section 75 and to align CAMHS services to the outcome of the recent review. Whilst not formally signed off, there has been agreement from the review to communicate to CAMHS staff that whilst service developments are anticipated, there will not be a reduction to the CAMHS budget. Planning for the developments is now commencing.

However, Southwark local authority have reduced their adult placement budget in 2018/19 by £700k to £2.4 million, putting the Trust at risk of non-payment of invoices once this level of expenditure is exceeded. The Trust is now reviewing this late decision to withdraw funding with Southwark local authority and Southwark CCG.

5.1 Lambeth and Croydon Alliances
The Lambeth Alliance commenced in July 2018 and the Trust is working with Alliance partners in delivering the new model via the Lambeth Borough Team.
The PMOA Operational Directorate are currently undergoing recruitment to the CPN posts confirmed as part of the Croydon Alliance.

5.2 Ann Moss Unit / Older Adult Specialist Care
Following a period of engagement and a joint review of the outcomes by SLaM and Southwark CCG, there was an agreement to proceed with the closure of Ann Moss Unit by August 31st 2018. As part of the ongoing engagement each patient had a health needs assessment and options for alternative care facilities were developed with their family and advocates on an individual basis.

The last patient left the unit on 16th July and there has been a period of transition where the patients have been followed up by the Ann Moss team and in the community Care Home Intervention Team.

Initially, from the eleven patients resident in Ann Moss, it was predicted five would need to come to move to the sister unit, Greenvale, in Lambeth. Following the reviews and work with relatives and carers only one person moved to Greenvale. The others went to nursing homes that specialised in dementia which was the preference of the families or identified in best needs meetings. This was to mitigate concerns raised that relatives will have further to travel to visit their loved ones after the closure and so there is a risk that relatives will lose regular contact with them.

In terms of staff, most have been redeployed to vacant posts in other facilities with support and trials on-going for other members of the team. A small redundancy programme is likely.

Greenvale Specialist Care Unit, located in Streatham, has now been designated the Older Adult Specialist Care Unit. It will be serving the 3 Boroughs of Southwark, Lambeth and Lewisham. This will be for older patients 65+ with a comorbidity of challenging behaviour due to mental health (organic and functional), learning disabilities and/or acquired brain injury and physical health. This provision has a new emphasis on shorter stays and care plans that will enable patients to be transferred to other facilities within Southwark and other Boroughs.

5.3 CAMHS
There are a number of CAMHS developments for the Board to note:

- NELFT NHS Foundation Trust are responsible for the delivery of Kent Community CAMHS services. NELFT approached SLaM to explore possible benefits of integrating community and inpatient services and these discussions have now been shared with commissioners – NHSE London and NHSE South. The proposal is for NELFT to provide the integrated service and due diligence work continues. SLaM staff have been briefed and are kept informed of developments.
- There are numerous CAMHS developments linked with the SLP, most recently, mobilisation of the new FCAMHS (Forensic CAMHS) service.
- Lambeth council have requested a detailed review of their contribution to the CAMHS budget and this is being undertaken in collaboration with the CCG.
- Following a successful bid for capital funding with NHSE for an LD / ASD service, a comprehensive and holistic intensive care model is being developed. Although capital funding was agreed in April, there have been on-going discussions and developments in the service model desired by commissioners. A revised plan is being developed for this initiative.

5.4 Commissioner-related Quality Impact Assessments (QIAs)
The Programme Management Office (PMO) undertakes the assurance and governance processes for QIAs. QIAs have been developed for most CIP schemes and are either approved or in draft for approval. There are currently no schemes in delivery that do not have an approved QIA. As new schemes are developed, they will be put through the rigour of the QIA process.
5.5 Commissioning Programmes 2017-18
2018-19 QIPP and CQUIN schemes are being managed using the PMO principles.

5.5.1 Quality, Innovation, Productivity and Prevention (QIPP) programme
QIPP has been rated into four categories:

<table>
<thead>
<tr>
<th>Rating</th>
<th>Definition</th>
<th>£'000s</th>
</tr>
</thead>
<tbody>
<tr>
<td>Red</td>
<td>Requires significant work</td>
<td>1,926</td>
</tr>
<tr>
<td>Amber</td>
<td>Requires some work</td>
<td>1,264</td>
</tr>
<tr>
<td>Green</td>
<td>Requires little work</td>
<td>5,314</td>
</tr>
<tr>
<td>Total</td>
<td></td>
<td>8,504</td>
</tr>
</tbody>
</table>

The QIPP risk dashboard is below:

<table>
<thead>
<tr>
<th>QIPP Ref</th>
<th>CCG</th>
<th>QIPP plan</th>
<th>Progress</th>
<th>Value (£)</th>
<th>RAG</th>
<th>YTD Variance (£)</th>
</tr>
</thead>
<tbody>
<tr>
<td>LAM-1819-005-Q</td>
<td>Lambeth</td>
<td>Lambeth Adult inpatient - baseline as per 17/18</td>
<td>QIPP offset by investment.</td>
<td>835</td>
<td>Red</td>
<td>278</td>
</tr>
<tr>
<td>STH-1819-003-Q</td>
<td>Southwark</td>
<td>Swk Adult inpatient - baseline as per 17/18</td>
<td>QIPP offset by investment.</td>
<td>532</td>
<td>Red</td>
<td>177</td>
</tr>
<tr>
<td>STH-1819-004-Q</td>
<td>Southwark</td>
<td>QIPP gap - initiatives to be identified</td>
<td>Initiatives to be identified</td>
<td>559</td>
<td>Red</td>
<td>143</td>
</tr>
<tr>
<td>LEW-1819-012-Q</td>
<td>Lewisham</td>
<td>FYE - Lewisham Community Teams - A&amp;L Team</td>
<td>Community teams budget (£42k) is in the baseline budget. Budgets will be monitored to track spend</td>
<td>42</td>
<td>Green</td>
<td>21</td>
</tr>
<tr>
<td>LEW-1819-013-Q</td>
<td>Lewisham</td>
<td>Placements reduction</td>
<td>New scheme, from former ERT £150k scheme.</td>
<td>50</td>
<td>Green</td>
<td>0</td>
</tr>
<tr>
<td>LEW-1819-014-Q</td>
<td>Lewisham</td>
<td>Primary care</td>
<td>New scheme, from former ERT £150k scheme.</td>
<td>50</td>
<td>Yellow</td>
<td>17</td>
</tr>
<tr>
<td>LEW-1819-015-Q</td>
<td>Lewisham</td>
<td>Homelessness</td>
<td>New scheme, from former ERT £150k scheme.</td>
<td>50</td>
<td>Yellow</td>
<td>17</td>
</tr>
<tr>
<td>LAM-1819-004-Q</td>
<td>Lambeth</td>
<td>SHARP</td>
<td>M1 variance of £33k</td>
<td>400</td>
<td>Yellow</td>
<td>49</td>
</tr>
<tr>
<td>STH-1819-002-Q</td>
<td>Southwark</td>
<td>Southwark Placements - CCG</td>
<td>Action plans being drafted</td>
<td>472</td>
<td>Green</td>
<td>0</td>
</tr>
</tbody>
</table>
LEW-1819-005-Q | Lewisham | QIPP Triage savings | Implementation in June 18 | 200 | 50

LAM-1819-006-Q | Lambeth | ASD & ADHD C&V expenditure | QIPP being achieved subject to CCG confirmation. | 150 | 0

PMOA-1819-011-Q | Lambeth | Greenvale - reduction in beds | QIPP being achieved | 666 | 0

PMOA-1819-010-Q | Southwark | Ann Moss Way | Service improvement | 893 | 0

LEW-1819-007-Q | Lewisham | FYE - IAPT (15% reduction) | QIPP being achieved | 93 | 0

LEW-1819-011-Q | Lewisham | FYE - LITT Team - move from Psychosis to primary (PMIC link) | QIPP being achieved | 43 | 0

CRY-1819-010-Q | Croydon | Croydon Adult inpatient - baseline as per 17/18 | OBD are within the plan and QIPP should be achieved (based M1 performance) | 2,333 | 0

CEN-1819-017-Q | NHSE | NHSE Specialist Contracts | QIPP offset by investment - 17/18 baseline has therefore been retained | 1,136 | 0

TOTAL | | | | 8,504 | 0

Fig. 19 QIPP dashboard

The QIPP position at month 4 is as follows:

All QIPPs that have not been delivered in 18/19 and where there is no agreement to reduce the baseline have been captured in the 18/19 business planning cycle with ongoing discussions in monthly performance management meetings to address the gap.

Majority of the QIPPs identified for 18/19 have robust plans that will be monitored in the monthly performance management meetings. All QIPPs are mapped to the new organisational structure.
**QIPP Red risks**

- **Southwark Adult inpatient (baseline as per 17/18). Value £532k.** QIPP offset by investment. This QIPP is red as although the baseline is reinstated, the Trust is over performing (more activity than income) against occupied bed day (OBD) baseline. Please note this is not a direct financial risk to the plan of £532k as the baseline funding reflects over performance and has been offset by additional CCG investment. However, the QIPP is noted as red given the requirement to achieve 85% bed occupancy and the potential financial impact on cost overall due to high bed occupancy.

- **Lambeth Adult inpatient (baseline as per 17/18). Value £835k.** QIPP has been offset by investment. This QIPP is red as although the baseline is reinstated, the Trust is over performing (more activity than income) against the occupied bed day (OBD) baseline. Please note this is not a direct financial risk to the plan of £835k as the baseline funding reflects over performance and has been offset by additional CCG investment. However, the QIPP is noted as red given the requirement to achieve 85% bed occupancy and the potential financial impact on cost overall due to high bed occupancy.

- **Southwark QIPP gap - initiatives to be identified. Value £559k.** Southwark CCG has not identified any initiative for this value. New initiatives have been proposed by the Trust, to the CCG in May, and the Trust is still awaiting a response.

**Amber Risks**

- **SHARP. Value £400k.** £400k QIPP & £133k CIP removed from annual budget. However, M4 budget confirms variance of £49k. This will be managed via PACMAN and recovery action plan is being drafted by the new Service Director for Southwark.

- **Lewisham Community Teams - A&L Team. Value £42k** This is a QIPP based on service improvement. There is a lack of clarity of a plan to deliver savings. Lewisham team are in the process of drafting a plan to recover the QIPP savings in year.

- **Southwark Placements. Value £472k.** This is being managed via Southwark PACMAN where performance is tracked and remedial initiatives are being identified. This QIPP is amber due to overspent budget and high spend placements trend from 17/18, and it is still unclear where Southwark Council sees its role in paying for its share of the agreement. Action plan is being drafted by the new Service Director for Southwark.

- **FYE - Lewisham Community Teams - A&L Team. Value £42k.** This is an outstanding issue that will be picked up as part of the borough restructure programme. This remains amber due to an overspend of £21k at M3

- **Lewisham ERT programme. Value £150k.** Agreement has been reached to break this into three separate programmes, each totalling £50k. The new schemes are Placements reduction, primary care, and homelessness. These will be updated in detail next month.

- **QIPP Triage savings. Value £200k.** This QIPP is amber because Implementation of this initiative has moved from May to early June, which is due to delay in seeking QIA approval.

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

The national CQUINs for 18/19 are consistent with 17/18, being the second year of implementation in the two year contract cycle signed for 17/19. The new local CQUINs are still being finalised for 18/19. The discussions are collaborative and reflect that agreement is being reached in year.

The Physical Health (CQUIN 3A & 3B 2018-19) scheme’s Q1 requirements have been moved to Q2 in agreement with commissioners, to allow sufficient time to embed new resource given the
departure of two medical leads during Q1. All other Q1 requirements for the other CQUIN schemes were submitted on time, including the Q1 delivery requirement for Reducing A&E Attendances scheme.

NHSE and Trust have agreed a year end close for 2017/18 CQUINs, with a credit due back to NHSE of about £98k, due to partial achievement of the Secure CQUIN milestones reported via the SLP. Trust is working in partnership with SLP colleagues to ensure robust monitoring and coordination of 2018/19 schemes to deliver full achievement. NHSE have moved Q1 milestone requirements to Q2 to provide more time for the partnership to align plans for delivery.

6. Programme Management Office (PMO)

6.1 Cost Improvement Programme (CIP)

The chart above shows the summary of the Trust CIP schemes broken down by Operational Delivery Unit (ODU) and by risk as at M4. The table shows that of the 70 schemes at £16.4m in the Trust plan, £3.8m are at high risk, this is driven primarily by overspill, borough restructure and agency costs. £6.6m is rated medium for risk, driven primarily by overspill. The remaining £5.9m is rated as low risk.
7. Finance

7.1 Current Position
At Month 5 YTD, the Trust had made a surplus of £1.3m, an adverse variance of £0.1m against its surplus control total.

Although the Trust remains on plan YTD, it faces a number of increasing cost pressures which unless tackled, could compound pressure on delivery of the plan that is back-loaded in terms of cost reductions.

As part of the Trust CIP plan to ensure discretionary expenditure is minimised, a number of Directorates and infrastructure services had year to date underspends ‘locked in’ this month, by transferring the appropriate budget (£1.9m) and holding it as a central non-recurring saving. This has distorted the in-month variance positions across a number of directorates.

The Trust is currently rated by NHSI as a 3 against use of resources (where 1 is best out of a 1-4 range). This rating relates to the finance performance of the Trust only - information on non-finance NHSI performance metrics, as they relate to the single oversight framework, are covered in other sections of the Performance report. The finance rating was originally scored at 2 but due to an override has been downgraded to a 3. The override kicks in due to a score of 4 against the Trust’s capital service cover. This score is in line with the ytd Plan and will improve by year end provided the Plan is met. However the score on use of agency staff is likely to deteriorate (currently a 2) as the Trust continues to employ considerably more agency staff than allowed for in its NHSI target.

7.2 Financial Risks & Key Issues
• Acute overspill averaged 30 beds in the month – a similar position to July – but showing signs of a decrease (currently standing at 22 as at 11/9/18). This number excludes local CCG patients over-spilling into Trust beds that were planned to be funded by NCA activity (non-contracted activity – primarily overseas and cross boundary flow patients). The net financial impact of overspill and loss of NCA income is £2m ytd after the impact of risk shares. Clearly this is a major risk to our financial plan if it continues at levels well above the 3 beds included in the plan. The main areas of concern continue to be Lambeth (18% above contract) and Southwark (11% above contract) but are now joined by Lewisham (10% above contract)

• Ward nursing costs rose considerably in August particularly in Lambeth. Although budgets are set at safer staffing levels, some wards are not able to keep within these establishments. The position is being compounded by the Agenda For Change (AfC) pay award which also covers bank staff and which is impacting disproportionately relative to our employed staff. All our nurse bank staff are paid on an increment point that attracts a higher level of pay award (7%) than other staff on the same band but on a different increment point. This fact has not been recognised in the pay award uplift from the Department of Health.

• Given the earlier than usual Board, the CIP/QIPP position reported here reflects its status as at month 4 rather than month 5. As at month 4, the Trust had generated CIP savings of £2m. The current adverse variance from the CIP plan of £1.8m is largely driven by our failure to meet acute overspill targets as indicated above. The Trust is largely meeting its CCG QIPP targets although it is not keeping to its baseline acute obd positions and there have been delays in restructuring the Social, Hope and Recovery Project in Lambeth. A gap remains on the Southwark QIPP plan where proposals to resolve have been put to the CCG.

• Complex placements are reporting a balanced position but this relies upon reaching a satisfactory agreement with Southwark Local Authority regarding its purchase of placement activity. The Trust has no contract with the LA and the LA have indicated they will only purchase £2.1m of
activity when activity is forecast to cost £4m. Discussions with both the CCG and LA are taking place to resolve this issue.

- The Trust had planned for a reduction in agency costs, in line with the new NHSI ceiling. However agency usage over the first 5 months is £1.1m above this ceiling. Although the new ceiling is £2.3m lower than last year, the position is being exacerbated by our agency costs also increasing. They are £0.4m higher than at this point last year and on current run rates will exceed the new ceiling by £3.8m at year end. Medical agency costs are disproportionally high with overall agency usage highest in the adult boroughs at 9% of pay costs.

- Last year the Trust, overall, met its cost and volume income targets (higher risk income that relates directly to increases/decreases in activity). However the overall performance masked areas where income was not on plan. Some of these areas have continued to underperform going into 2018/19, whilst others have moved from a surplus into a deficit and are now driving a bottom line income deficit of £1.8m at month 5. Corresponding pay underspends will mitigate 40% of this variance but a number of services are required to improve their performance over the remaining 7 months.

- The backdated element of the AfC pay award hit the accounts this month. Although established pay budgets have been uplifted in line with the award, sufficient funding has not been provided by the Department of Health to cover this increase in cost. The Department acknowledge it is not fully funded and have requested details as part of our monthly monitoring submission to NHSI. These will be provided in our return due in on 17/9/18. However it seems unlikely that any further funding will be made available and this cost pressure will need to be taken account of in our forecast position. It is also unclear how the recently announced medical award will be funded which again has been agreed at a level above that funded within the CCG tariff uplift.

7.3 Financial Risks & Key Issues
At month 5, the Trust is still forecasting to meet its NHSI control total. The Trust has identified financial risks though totalling c£6m by year end (excluding the Southwark LA placements issue described above). These can be mitigated against provided –

- The SLP delivers net savings in line with the Trust plan
- Outstanding QIPP issues are resolved with Southwark CCG

The remaining risk (c£4.8m) will need to be addressed by bringing down the current run rates in key areas previously outlined –

- Acute overspill
- Ward nursing costs
- High agency costs
- Variable (activity driven) income shortfalls
- Infrastructure overspends particularly in Estates and HR
- Junior doctor costs
- On-going delivery of CIPs (current and those planned for later in the year)
## 7.4 Financial Summary

<table>
<thead>
<tr>
<th>Service Analysis</th>
<th>Monthly Figures</th>
<th>Year to Date Figures</th>
<th>Year To Date Actual (£)</th>
<th>Variance From Live Budgets (£)</th>
<th>Variance From Live Budgets (£)</th>
<th>Variance Last Month (£)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Full Year Live Budgets (£)</td>
<td>Current Month Actual (£)</td>
<td>Variance From Live Budgets (£)</td>
<td>Year To Date Actual (£)</td>
<td>Variance From Live Budgets (£)</td>
<td>Variance Last Month (£)</td>
</tr>
<tr>
<td>01. Lambeth</td>
<td>22,353,900</td>
<td>2,211,900</td>
<td>461,000</td>
<td>10,185,800</td>
<td>886,100</td>
<td>422,600</td>
</tr>
<tr>
<td>02. Southwark</td>
<td>29,362,400</td>
<td>2,909,400</td>
<td>742,300</td>
<td>12,457,700</td>
<td>477,400</td>
<td>(257,600)</td>
</tr>
<tr>
<td>03. Lewisham</td>
<td>23,577,700</td>
<td>2,423,900</td>
<td>352,900</td>
<td>10,694,300</td>
<td>919,500</td>
<td>566,500</td>
</tr>
<tr>
<td>04. Croydon</td>
<td>15,796,000</td>
<td>1,987,600</td>
<td>802,800</td>
<td>7,749,300</td>
<td>1,410,600</td>
<td>542,900</td>
</tr>
<tr>
<td>05. PMOA</td>
<td>(986,200)</td>
<td>124,500</td>
<td>265,600</td>
<td>(630,900)</td>
<td>(111,800)</td>
<td>(377,300)</td>
</tr>
<tr>
<td>06. Child &amp; Adolescent Service</td>
<td>509,400</td>
<td>306,000</td>
<td>286,900</td>
<td>740,700</td>
<td>628,900</td>
<td>342,000</td>
</tr>
<tr>
<td>07. Clinical Support Services</td>
<td>8,520,600</td>
<td>689,200</td>
<td>(44,900)</td>
<td>3,477,900</td>
<td>(72,300)</td>
<td>(27,400)</td>
</tr>
<tr>
<td>08. Infrastructure Directorates</td>
<td>63,438,800</td>
<td>6,469,900</td>
<td>827,700</td>
<td>29,363,100</td>
<td>1,041,700</td>
<td>274,300</td>
</tr>
<tr>
<td>09. Corporate Income</td>
<td>(105,604,700)</td>
<td>(8,924,500)</td>
<td>(244,000)</td>
<td>(43,862,900)</td>
<td>(285,500)</td>
<td>(41,600)</td>
</tr>
<tr>
<td><strong>Operational Deficit</strong></td>
<td>56,967,900</td>
<td>8,197,900</td>
<td>3,450,300</td>
<td>30,175,000</td>
<td>4,894,600</td>
<td>1,444,400</td>
</tr>
<tr>
<td>10. Corporate Other</td>
<td>(79,106,900)</td>
<td>(8,652,500)</td>
<td>(2,119,600)</td>
<td>(32,928,700)</td>
<td>(380,300)</td>
<td>1,739,300</td>
</tr>
<tr>
<td>11. Contingency - planned</td>
<td>1,800,000</td>
<td>0</td>
<td>(150,000)</td>
<td>0</td>
<td>(750,000)</td>
<td>(600,000)</td>
</tr>
<tr>
<td>12. Other reserves/provisions</td>
<td>8,251,000</td>
<td>0</td>
<td>(990,500)</td>
<td>0</td>
<td>(3,642,500)</td>
<td>(2,652,000)</td>
</tr>
<tr>
<td><strong>Corporate Other</strong></td>
<td>(69,055,900)</td>
<td>(8,652,500)</td>
<td>(3,260,100)</td>
<td>(32,928,700)</td>
<td>(4,772,800)</td>
<td>(1,512,700)</td>
</tr>
<tr>
<td><strong>EBITDA</strong></td>
<td>(12,088,000)</td>
<td>(454,600)</td>
<td>190,200</td>
<td>(2,753,700)</td>
<td>121,800</td>
<td>(68,300)</td>
</tr>
<tr>
<td>13. Post EBITDA Items</td>
<td>10,110,000</td>
<td>1,332,200</td>
<td>(17,500)</td>
<td>1,430,300</td>
<td>(8,000)</td>
<td>9,500</td>
</tr>
<tr>
<td><strong>Trust Financial Position</strong></td>
<td>(1,978,000)</td>
<td>877,600</td>
<td>172,700</td>
<td>(1,323,400)</td>
<td>113,800</td>
<td>(58,800)</td>
</tr>
<tr>
<td>Items Not Included In NHSI Target</td>
<td>(480,900)</td>
<td>(43,000)</td>
<td>(24,000)</td>
<td>(220,000)</td>
<td>(20,000)</td>
<td>4,000</td>
</tr>
<tr>
<td><strong>NHSI Control Total</strong></td>
<td>(2,458,900)</td>
<td>834,600</td>
<td>148,700</td>
<td>(1,543,400)</td>
<td>93,800</td>
<td>(54,800)</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Area</th>
<th>2017/18 Total Variance £000</th>
<th>2018/19 Mth 1 Variance £000</th>
<th>2018/19 Mth 2 Variance £000</th>
<th>2018/19 Mth 3 Variance £000</th>
<th>2018/19 Mth 4 Variance £000</th>
<th>2018/19 Mth 5 Variance £000</th>
<th>2018/19 Total Variance £000</th>
</tr>
</thead>
<tbody>
<tr>
<td>CAGs</td>
<td>4,340</td>
<td>336</td>
<td>391</td>
<td>831</td>
<td>(317)</td>
<td>2,969</td>
<td>4,210</td>
</tr>
<tr>
<td>Infrastructure Directorates</td>
<td>6,607</td>
<td>455</td>
<td>82</td>
<td>(127)</td>
<td>(164)</td>
<td>724</td>
<td>970</td>
</tr>
<tr>
<td>Corp Income</td>
<td>(599)</td>
<td>(48)</td>
<td>(89)</td>
<td>(129)</td>
<td>224</td>
<td>(244)</td>
<td>(286)</td>
</tr>
<tr>
<td>Other including provisions released &amp; central CIPs</td>
<td>(1,554)</td>
<td>336</td>
<td>760</td>
<td>422</td>
<td>221</td>
<td>(2,118)</td>
<td>(379)</td>
</tr>
<tr>
<td>Use of Reserves</td>
<td>(1,772)</td>
<td>(1,210)</td>
<td>(1,309)</td>
<td>(815)</td>
<td>82</td>
<td>(1,141)</td>
<td>(4,393)</td>
</tr>
<tr>
<td><strong>Total EBITDA</strong></td>
<td>7,022</td>
<td>(131)</td>
<td>(165)</td>
<td>182</td>
<td>46</td>
<td>190</td>
<td>122</td>
</tr>
</tbody>
</table>
7.5 Key Cost Drivers (unmitigated by alternative income, risk shares etc.)

<table>
<thead>
<tr>
<th>Area</th>
<th>2017/18 Total Variance £000</th>
<th>2018/19 Mth 1 Variance £000</th>
<th>2018/19 Mth 2 Variance £000</th>
<th>2018/19 Mth 3 Variance £000</th>
<th>2018/19 Mth 4 Variance £000</th>
<th>2018/19 Mth 5 Variance £000</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ward Nursing*</td>
<td>2,079</td>
<td>214</td>
<td>151</td>
<td>153</td>
<td>206</td>
<td>681</td>
</tr>
<tr>
<td>Agency Premium @ 20%</td>
<td>2,857</td>
<td>220</td>
<td>285</td>
<td>270</td>
<td>254</td>
<td>285</td>
</tr>
<tr>
<td>Acute Overspill***</td>
<td>4,415</td>
<td>265</td>
<td>487</td>
<td>679</td>
<td>594</td>
<td>867</td>
</tr>
<tr>
<td>Unmet CIPs***</td>
<td>1,546</td>
<td>166</td>
<td>307</td>
<td>423</td>
<td>870</td>
<td>tbc</td>
</tr>
<tr>
<td>Placements***</td>
<td>2,027</td>
<td>(98)</td>
<td>(84)</td>
<td>(111)</td>
<td>60</td>
<td>(70)</td>
</tr>
<tr>
<td>CPC/C&amp;V Income</td>
<td>(357)</td>
<td>340</td>
<td>340</td>
<td>406</td>
<td>426</td>
<td>324</td>
</tr>
<tr>
<td>Total</td>
<td>12,569</td>
<td>1,107</td>
<td>1,486</td>
<td>1,820</td>
<td>2,410</td>
<td>tbc</td>
</tr>
</tbody>
</table>

* includes safer staffing funding **see Section 3 *** before application of risk shares & excl Swk LA funding issue

Performance against the main cost drivers are detailed below –

- **Acute/PICU Overspill**

Overall 30 overspill beds were used by the Trust in August, a similar figure to the previous month and 27 beds above our original plan. This number has decreased though going into September. The main drivers of this contract overperformance and hence resort to using beds outside the Trust continue to be Lambeth and Southwark but are now joined by Lewisham where overperformance has increased markedly in the month. The use of overspill and other non-local CCG beds has resulted in a cost pressure, after application of risk shares, of £2m after 5 months. The Trust response to this is picked up in other sections of the Performance Report.

- **Use of Agency Staff**

NHSI have set a ceiling to spend no more than £15.1m on all agency staff. By way of comparison, the Trust spent £17.2m on agency in 2017/18. The Trust is currently £1.1m above that ceiling at month 5 and at present rates of expenditure will be £3.8m above the ceiling at year end and in excess of its 2017/18 position. Agency cost reductions form part of the annual plan and rely upon meeting the NHSI ceiling. As at month 5 ytd the Trust had incurred an additional expense of c£1.3m above the cost of employing permanent SLaM staff, assuming a 20% agency premium.
Medical agency costs increased in month 5 and now represent 26% of total agency costs (a disproportionately high level of spend compared to other groups of staff). A breakdown of all agency use compared to permanent/bank usage ytd is given below –

<table>
<thead>
<tr>
<th>Directorate</th>
<th>All Staff £000</th>
<th>Agency Usage £000</th>
<th>Agency Usage %</th>
</tr>
</thead>
<tbody>
<tr>
<td>Lambeth</td>
<td>12,830</td>
<td>1,201</td>
<td>9%</td>
</tr>
<tr>
<td>Southwark</td>
<td>15,569</td>
<td>1,237</td>
<td>8%</td>
</tr>
<tr>
<td>Lewisham</td>
<td>11,006</td>
<td>961</td>
<td>9%</td>
</tr>
<tr>
<td>Croydon</td>
<td>21,818</td>
<td>2,107</td>
<td>10%</td>
</tr>
<tr>
<td>PMOA</td>
<td>14,978</td>
<td>456</td>
<td>3%</td>
</tr>
<tr>
<td>CAMHS</td>
<td>14,979</td>
<td>831</td>
<td>6%</td>
</tr>
<tr>
<td>Other</td>
<td>27,557</td>
<td>1,096</td>
<td>4%</td>
</tr>
<tr>
<td>Total</td>
<td>118,736</td>
<td>7,889</td>
<td>7%</td>
</tr>
</tbody>
</table>

- **Ward/Unit Nursing Costs**

At month 5 ward nursing costs overspent by £681k (£1.4m ytd). This is an increase compared to previous months and takes account of the pay award that is due to bank staff. Although all the nurse budgets were increased in July (substantive staff pay rates increased this month), nurse bank pay rates lag one month behind and did not increase until August. This month’s variance makes an allowance for this and the fact that NHS Professionals (who run our nurse bank) estimate the pay ward will increase our costs by 7%. This is higher than the average increase due to the incremental point that our bank staff are paid on. The % pay award can be different for people on the same band depending which incremental point they sit on. Our bank staff are paid on an incremental point that attracts a higher than average increase. This has not been recognised in the NHSE funding settlement that attempted to meet the cost of the pay award in full.

The increase in costs would appear to be a combination of the unfunded element of the bank pay award plus an increase in activity over both the holiday period and the period when CQC were
undertaking their visit. The main areas of concern are the Lambeth, Lewisham and Croydon adult wards which represent 80% of the total ward/unit nurse overspend. Included within this are Eden PICU (Lambeth), Johnson Unit PICU (Lewisham) and Fitzmary 1 (Croydon) which are all +20% above their funded nurse establishments.

Fig. 22 Trust's nursing overspend

- **Cost per Case/Cost and Volume Income (variable income aligned to activity)**

<table>
<thead>
<tr>
<th>CAG</th>
<th>Income Target At Month 5 £'000</th>
<th>Actual Invoiced At Month 5 £'000</th>
<th>Surplus/ Deficit(−) At Month 5 £'000</th>
</tr>
</thead>
<tbody>
<tr>
<td>Lambeth</td>
<td>1,083</td>
<td>1,162</td>
<td>(79)</td>
</tr>
<tr>
<td>Southwark</td>
<td>659</td>
<td>684</td>
<td>(25)</td>
</tr>
<tr>
<td>Lewisham</td>
<td>253</td>
<td>286</td>
<td>(33)</td>
</tr>
<tr>
<td>Croydon</td>
<td>12,341</td>
<td>12,090</td>
<td>251</td>
</tr>
<tr>
<td>PMOA</td>
<td>8,074</td>
<td>7,407</td>
<td>667</td>
</tr>
<tr>
<td>CAMHS</td>
<td>9,929</td>
<td>8,874</td>
<td>1,055</td>
</tr>
<tr>
<td><strong>TOTAL</strong></td>
<td><strong>32,339</strong></td>
<td><strong>30,503</strong></td>
<td><strong>1,836</strong></td>
</tr>
</tbody>
</table>

The position has deteriorated from 2017/18, with 3 Directorates standing out –

- Croydon – income below target on Forensic Ward in the Community (additional beds not occupied), Psychosis Unit (activity below plan including a provision for bad debts), NAU (reduction in beds/income due to building works) and Pick Up service (revised target not being met). In addition the ADHD clinics are now only breaking even whereas last year they were over performing against reduced income targets.

- PMOA – part of this year’s CIP programme was to retain the 17/18 income targets but make progress towards meeting them. This is yet to occur uniformly with some of those services that underperformed last year - in particular, neuropsychiatry and eating disorders inpatients & outpatients – continuing to underperform. In addition Chronic Fatigue, Affective Disorders and the Centre For Anxiety Disorders and Trauma are not currently meeting activity targets.
- CAMHS – the underperformance largely relates to outpatient services, in particular the Conduct Adoption and Fostering service and the Children’s Forensic Team where insufficient activity is taking place to fully meet costs. There is likely to be some catch up in terms of activity being recorded on the systems or timing of income due such that some improvement is expected in line with previous years. However there are also income shortfalls on inpatient services where activity remains below target in Kent and on Snowfields whilst delays in converting beds at Acorn Lodge into high dependency beds means income targets are also not being met. The new PICU Unit is expected to be fully open later in the year ensuring that its income targets will be met.

Some of these shortfalls (40% by value) are being offset by corresponding net pay underspends but it is important that follow up action is taken to mitigate these income positions wherever possible.

- Complex Placements

Placements are currently in balance largely achieved through a combination of additional income (Southwark CCG) and changes to budget as allowed for in the Annual Plan. However there remains a high risk on Southwark local authority placements where funding is no longer being routed through the CCG contract under a Section 75 agreement. Previously this provided the Trust with some certainty as the CCG effectively underwrote any issues that the CCG had with the Local Authority as regards recovery of funding. The Trust must now invoice the Local Authority direct in order to recover costs which last year overspent by £0.8m against a baseline budget of £3.1m. As at month 5 the LA element of placements has cost £1.65m with zero recovery as yet from Southwark Council. The Council have indicated they are only willing to purchase activity up to a value of £2.4m leaving a potential forecast gap of £1.6m. This situation is being taken up with the Council/CCG with further discussions taking place on 24th September.
8. Emergency Planning

In response to the 2017 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 and the inaugural meeting of this group will take place in August 2018, chaired by the Chief Operating Officer.

Working groups and a project board have been set up to address the areas of non-compliance as highlighted in the NHSE (London) annual EPRR assurance process from November 2017. These complement existing performance review meetings across the Trust. Key areas are as follows:

- The Trust has created a new EPRR Specialist Manager post, to be recruited to imminently. The post will lead on delivering specialised EPRR objectives for the organisation.
- The Trust is in the process of formalising its lockdown plan (to be included in the Secure Environments policy).
- The Trust is updating Business Continuity plans to reflect the recent move to Borough based operational directorates. A training needs analysis will be undertaken for both on-call directors and the wider organisation in relation to EPRR, focusing on specific aspects of risk.
- The Trust has its latest Disaster Recovery (DR) plan in draft, awaiting ratification and submission to NHSE (London). It is anticipated that this plan will be ratified imminently.
- The Trust is continuing with Business Continuity exercises and the on-going work with NHSE (London), and the LAS (London Ambulance Service) to develop a Hazardous Materials (HazMat) and Chemical Biological Radiological Nuclear and explosives (CBRNe) ‘train the trainer’ course, specifically aimed at Mental Health Trusts. A pilot training session took place in May, which was attended by both departmental representatives from SLaM, and representation from NHSE (London).
- A core EPRR team is currently preparing an updated version of the Emergency and Major Incident Plan (EMIP), to be presented to the September meeting of the Board.

The Trust has moved the risk associated with EPRR from the Executive Risk Register to the COO Delivery Risk Register.
9. Conclusion
The Trust continues to meet the NHS Improvement Single Oversight Framework indicators covered by this report.

Pressure across the adult acute pathway (inpatient and community) has increased and is resulting in continued usage of external overspill inpatient beds. The first multi-agency discharge event (MADE) was held in Southwark in July and the next one is planned in September for Croydon.

The Programme Management Office is now supporting the 18/19 oversight process for CIP, QIPP and CQUIN. £3.8 million of the CIP programme is currently rated as high risk.

There is an agreed approach with commissioners to evaluate their investment plans and the Five Year Forward View transformation trajectories.

We continue to work with both Southwark Local Authority and CCG to evaluate the impact of the proposed changes regarding section 75 and to align CAMHS services to the outcome of the recent review; the risk from the reduction in placements budget by Southwark Local Authority is being assessed.

The Performance Management Framework is being reviewed as part of the development of the borough operational delivery model.

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

<table>
<thead>
<tr>
<th>Abbreviation</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>AEP</td>
<td>Accountable Emergency Officer</td>
</tr>
<tr>
<td>AfC</td>
<td>Agenda for Change</td>
</tr>
<tr>
<td>Ascom</td>
<td>Alarm / communications system supplied by Ascom UK, a telecommunications company</td>
</tr>
<tr>
<td>ASD / LD</td>
<td>Autism Spectrum Disorder / Learning Disability</td>
</tr>
<tr>
<td>CAG</td>
<td>Clinical Academic Group – bringing together clinical services, research and education and training into a single management grouping e.g. Psychosis</td>
</tr>
<tr>
<td>CAMHS</td>
<td>Child and Adolescent Mental Health Services</td>
</tr>
<tr>
<td>CBT</td>
<td>Cognitive Behavioural Therapy (CBTp is CBT of psychosis)</td>
</tr>
<tr>
<td>CCG</td>
<td>Clinical Commissioning Group – an NHS body responsible for the planning and commissioning of health services for their local area</td>
</tr>
<tr>
<td>CHS</td>
<td>Croydon Health Services NHS Trust</td>
</tr>
<tr>
<td>CPA</td>
<td>Care Programme Approach</td>
</tr>
<tr>
<td>CQUIN</td>
<td>Commissioning for Quality and Innovation: A fund where payment is contingent on delivery on quality improvements and meeting milestones agreed with commissioners.</td>
</tr>
<tr>
<td>CYP</td>
<td>Children &amp; Young People</td>
</tr>
<tr>
<td>DBT</td>
<td>Dialectical Behaviour Therapy</td>
</tr>
<tr>
<td>DTOC</td>
<td>Delayed Transfers of Care</td>
</tr>
<tr>
<td>EI</td>
<td>Early Intervention: First Episode Psychosis</td>
</tr>
<tr>
<td>ePJS</td>
<td>Electronic Patient Journey System: Clinical records system</td>
</tr>
<tr>
<td>EPM</td>
<td>Emergency Planning Manager</td>
</tr>
<tr>
<td>EPRR</td>
<td>Emergency Preparedness, Resilience and Response</td>
</tr>
<tr>
<td>GSTT</td>
<td>Guys &amp; ST Thomas’ NHS Foundation Trust</td>
</tr>
<tr>
<td>HTT</td>
<td>Home Treatment Team</td>
</tr>
<tr>
<td>IAPT</td>
<td>Improving Access to Psychological Therapies</td>
</tr>
<tr>
<td>JOSC</td>
<td>Joint Overview and Scrutiny Committee</td>
</tr>
<tr>
<td>LoS</td>
<td>Length of Stay. The duration of an inpatient stay, usually measured in days. Can include or exclude leave and can focus on a stay on a particular ward or the full hospital admission.</td>
</tr>
<tr>
<td>LSLC</td>
<td>Lambeth, Southwark, Lewisham &amp; Croydon (CCGs)</td>
</tr>
<tr>
<td>MHOAD</td>
<td>Mental Health of Older Adults and Dementia</td>
</tr>
<tr>
<td>MHSDS</td>
<td>Mental Health Services Data Set: National dataset submitted to NHS Digital (formerly known as the Health &amp; Social Care Information Centre)</td>
</tr>
<tr>
<td>NHSE</td>
<td>NHS England</td>
</tr>
<tr>
<td>NHSE(L)</td>
<td>NHS England (London)</td>
</tr>
<tr>
<td>NHSI</td>
<td>NHS Improvement: the new regulatory body overseeing all NHS providers as well as independent providers that provide NHS funded care</td>
</tr>
<tr>
<td>NHSP</td>
<td>NHS Professionals</td>
</tr>
<tr>
<td>NICE</td>
<td>National Institute for Health and Care Excellence: provides national guidance and advice to improve health and social care</td>
</tr>
<tr>
<td>Term</td>
<td>Description</td>
</tr>
<tr>
<td>--------</td>
<td>-----------------------------------------------------------------------------</td>
</tr>
<tr>
<td>OAP</td>
<td>Out of Area Placement</td>
</tr>
<tr>
<td>OBD</td>
<td>Occupied Bed Day – is a unit of currency used to measure the use made of a bed</td>
</tr>
<tr>
<td></td>
<td>(e.g. 1 obd = 1 bed occupied for 1 day by a patient)</td>
</tr>
<tr>
<td>PACMAN</td>
<td>Performance and Contract Management (meeting)</td>
</tr>
<tr>
<td>PICU</td>
<td>Psychiatric Intensive Care Unit</td>
</tr>
<tr>
<td>PMF</td>
<td>Performance Management Framework</td>
</tr>
<tr>
<td>PMO</td>
<td>Programme Management Office</td>
</tr>
<tr>
<td>QIA</td>
<td>Quality Impact Assessment</td>
</tr>
<tr>
<td>QIPP</td>
<td>Quality, Innovation, Productivity and Prevention programme is a series of schemes required by the CCGs and developed with SLaM to help enhance services and improve their cost effectiveness</td>
</tr>
<tr>
<td>QuESTT</td>
<td>Quality, Effectiveness and Safety Trigger Tool. An inpatient self-audit which enables pressures in inpatient wards to be quantified. In 2018 a simple community equivalent is being developed and introduced at SLaM.</td>
</tr>
<tr>
<td>SEL</td>
<td>South East London</td>
</tr>
<tr>
<td>SLP</td>
<td>South London Mental Health and Community Partnership. A partnership of SLaM, Oxleas and SWLStG formed in 2015</td>
</tr>
<tr>
<td>SOF</td>
<td>Single Oversight Framework: NHSI assurance and performance mechanism</td>
</tr>
<tr>
<td>SPC</td>
<td>Statistical Process Control</td>
</tr>
<tr>
<td>STP</td>
<td>Sustainability and Transformation Partnership</td>
</tr>
<tr>
<td>SWL</td>
<td>South West London</td>
</tr>
<tr>
<td>SWLStG</td>
<td>South West London and St George’s Mental Health NHS Trust</td>
</tr>
<tr>
<td>YTD</td>
<td>Year to Date</td>
</tr>
</tbody>
</table>
Community QESTT Dashboard - Workforce
Version 0.4
Title: Board Assurance Framework

Purpose of the paper:
The purpose of the paper is to provide a review of the Board Assurance Framework and an overview of the next steps being taken to provide assurance that agreed actions are progressing.

Executive summary:
This paper presents the Board Assurance Framework (BAF) for September 2018 as part of the agreed oversight and governance arrangements.

Since the last Board BAF review June 2018, the Board has considered risk focus reports for BAF 9 (estates) and 13 (mandatory training) and the BAF has been update accordingly.

Further updates to the BAF have been made particularly light of the operational restructure and the implications of the CQC inspection findings.

This paper also summarises changes to the Executive Risk Register (ERR)

Risks / issues for escalation:
The report relates directly to all BAF risks.

Committees where this item has been considered:

<table>
<thead>
<tr>
<th>Date</th>
<th>Committee / Meeting</th>
</tr>
</thead>
<tbody>
<tr>
<td>11 Sep 2018</td>
<td>Quality Committee</td>
</tr>
<tr>
<td>17 Sep 2018</td>
<td>Audit Committee</td>
</tr>
</tbody>
</table>

BAF report – September 2018

1. Introduction
1.1 This report presents the Board Assurance Framework (BAF) for September 2018 as part of the agreed oversight and governance arrangements.

1.2 Since the last update in June 2018, the Board received risk focus reports for BAF risks 9 (19/6/18), BAF risk 13 (24/7/18) and BAF risk 7 (18/9/18).
1.3 The significant changes to the BAF are set out in this report together with an update on the Executive Risk Register (ERR).

2. BAF update

2.1 The revised draft BAF is attached as appendix 1.

2.2 The significant changes to the BAF since the last update in June 2018 are set out below:

2.3 Following recommendations by Internal Audit the BAF template for each individual risk now includes a section for “action plan progress summary” to enable the Board to be provided with an appropriate statement that indicates the position of action plans in addressing the gaps in control and assurance. The full detailed plans are maintained by the relevant Executive Director and will be uploaded to Datix for assurance/audit purposes.

2.4 The risks approved at the June Board for closure/de-escalation (BAF risks 4, 6 & 10) have been removed from the BAF summary report, the heat map and the individual risk pages deleted.

2.5 Following Board members requests for a more effective way of referring to BAF risks during discussions than the current unhelpful assigned risk number, each BAF risk has been assigned a suitable shorthand subject descriptor. An additional column has been added to the summary report page and the subject descriptor added to the headline of each individual risk.

2.6 The Estates risk (BAF 9) has been significantly updated as approved by the Board’s deep dive review (June Board).

2.7 As a result of the verbal feedback following the CQC inspection and the subsequent warning notice (regulation 29A HSCA) in relation to the variability of fundamental standards of care across the Acute pathway, it is proposed the quality & statutory compliance risk (BAF 7) should be significantly revised and in particular the risk likelihood increased to 4 and hence the overall risk to 16 (red rated risk). The detailed discussion and proposals for this risk is the subject of a separate risk focus report to the Board which will be considered with a report into the outcome of the CQC inspection.

2.8 The risk rating of the operational delivery structure risk (BAF 2) has been reviewed in light of the borough restructure delivery and the implications of the CQC inspection findings. Although the organisational restructure to a borough based model has been successfully delivered, any potential mitigation of the likelihood of the risk has been offset by the concerns relating to inconsistent delivery of quality and standards of care raised by the recent CQC inspection. Accordingly it is recommended the current risk rating level is retained.

2.9 However a number of additional key controls have been added together with some minor textual changes to gaps in control, sources of assurance and gaps in assurance.

2.10 Minor textual updates have also been made to:-

- Workforce (BAF 1) in key controls & gaps in assurance
- Finance – contracts (BAF 8) in gaps in assurance
- QI delivery (BAF 11) in gaps in control, sources of assurance and assurance on the effectiveness of controls
- Finance – cost management (BAF 12) in gaps in assurance
- Mandatory training (BAF 13) in key controls and assurance on the effectiveness of controls

2.11 No changes were considered necessary to the informatics risk (BAF 3) or partnership working with service users risk (BAF 5).

2.12 With the increased risk for quality & statutory compliance (BAF 7) the BAF now has 4 red rated risks and 6 amber rated risks. The graph below shows the risk rating level changes over time.
Finally, it is worth noting that both recent Board risk focus reviews have resulted in changes to their risk descriptions. As most of the risk descriptions of the BAF risks have not been amended since they were written last year and as noted at the last Board may benefit from being simplified it is recommended that Committees are encouraged to critically review all the BAF risk descriptions.

### 3. Oversight and governance

3.1 As part of the BAF oversight and governance arrangements each BAF risk has been assigned to a responsible Executive Director and a Board level committee for oversight of each risk and its controls.

3.2 Since the last BAF update, the relevant board level committees have considered issues, controls and assurance monitoring associated with the BAF principle risks, summarised in the table 1 below.

<table>
<thead>
<tr>
<th>Board Level Committee</th>
<th>BAF related agenda items</th>
<th>BAF risk addressed</th>
</tr>
</thead>
<tbody>
<tr>
<td>Quality Committee 17/7/18</td>
<td>Quality Priorities</td>
<td>1,3,5,7,9,11</td>
</tr>
<tr>
<td></td>
<td>Performance and Contract Management Report</td>
<td>2,3,6,8,12</td>
</tr>
<tr>
<td></td>
<td>Quality Governance Compliance Report</td>
<td>1,3,5,7,9,11</td>
</tr>
<tr>
<td></td>
<td>QC BAF risks - deep dive</td>
<td>2,5,7,11</td>
</tr>
<tr>
<td></td>
<td>CQC Safety Deep Dive</td>
<td>1,2,7</td>
</tr>
<tr>
<td></td>
<td>Medicines management: annual report 2017-18</td>
<td>2,5,8</td>
</tr>
<tr>
<td></td>
<td>Safeguarding Adults Annual Report 2017/18</td>
<td>2,3,5,6,7</td>
</tr>
<tr>
<td></td>
<td>Mandatory Training Report</td>
<td>13</td>
</tr>
<tr>
<td></td>
<td>Development of Trust data framework – update</td>
<td>3,7</td>
</tr>
<tr>
<td></td>
<td>Smoke free annual update</td>
<td>5</td>
</tr>
<tr>
<td></td>
<td>Mental Health Law Committee update</td>
<td>7</td>
</tr>
<tr>
<td></td>
<td>Complaints Annual Report 2017/2018</td>
<td>2,5,7</td>
</tr>
<tr>
<td></td>
<td>Quality, Safety, Effectiveness Trigger Tool (QuESTT)</td>
<td>1,2,7</td>
</tr>
<tr>
<td></td>
<td>Croydon Alliance Red Lines Review</td>
<td>2,7,8</td>
</tr>
<tr>
<td></td>
<td>Policy for the Development and Management of Trust wide Policies</td>
<td>2,7</td>
</tr>
<tr>
<td>Finance &amp; Performance Committee 23/7/18</td>
<td>Procurement Department Transformation options paper</td>
<td>1,12</td>
</tr>
<tr>
<td></td>
<td>Capital Planning, Estates and Facilities (CEF) Dashboard</td>
<td>1,9,11,12</td>
</tr>
<tr>
<td></td>
<td>Board Assurance Framework update</td>
<td>All</td>
</tr>
<tr>
<td></td>
<td>2018/19 planning: update</td>
<td>1,7,12</td>
</tr>
<tr>
<td></td>
<td>Performance Report</td>
<td>2,3,8,11,12</td>
</tr>
<tr>
<td></td>
<td>Payroll</td>
<td>12</td>
</tr>
<tr>
<td>BDIC 23/7/18</td>
<td>CYP Outline Business Case</td>
<td>9</td>
</tr>
<tr>
<td></td>
<td>Maudsley Health UAE Update</td>
<td>8</td>
</tr>
<tr>
<td></td>
<td>MRI Tender Recommendation Paper</td>
<td>12</td>
</tr>
<tr>
<td></td>
<td>Centre for Translational Informatics CTI Joint KCL</td>
<td>2,3,11</td>
</tr>
</tbody>
</table>

Table 1 Summary of BAF risks considered at Board level committees
4. Executive Risk Register (ERR)

4.1 The ERR is the highest level of the Trust risk register structure that contain all the risks escalated from Operational and Corporate Directorate risk resisters (due to their significant consequences, potential trust wide impacts, being too large to be effectively managed at the Operational/Corporate Directorate level, or having a significant residual risk despite all mitigation measures have been implemented) as well as the BAF risks.

4.2 The ERR is reviewed monthly by SMT. At the last SMT review, 1 new risk was accepted for escalation to the ERR, no risks were de-escalated and no existing ERR risks were re-rated.

4.3 There are currently 24 risks on the ERR of which 5 are red rated risks with the remaining 19 amber rated risks. The graph below show the spread of risk ratings for the ERR risks.

![Risk Rating Distribution](image)

4.4 The table below lists the ERR risks that are not currently included in the BAF.

<table>
<thead>
<tr>
<th>Ref</th>
<th>Title</th>
<th>Current risk rating</th>
<th>Target</th>
<th>ED lead</th>
</tr>
</thead>
<tbody>
<tr>
<td>ERR33</td>
<td>Clinic room temperatures</td>
<td>16</td>
<td>6</td>
<td>Beverley Murphy</td>
</tr>
<tr>
<td>ERR10</td>
<td>Suicide prevention</td>
<td>15</td>
<td>10</td>
<td>Beverley Murphy</td>
</tr>
<tr>
<td>ERR01</td>
<td>There is a risk of interruption to IT service delivery/operations</td>
<td>12</td>
<td>12</td>
<td>Gus Heafield</td>
</tr>
<tr>
<td>ERR02</td>
<td>Non-compliance with IG national standards</td>
<td>12</td>
<td>8</td>
<td>Gus Heafield</td>
</tr>
<tr>
<td>ERR03</td>
<td>Violence &amp; restrictive practices</td>
<td>12</td>
<td>9</td>
<td>Kristin Dominy</td>
</tr>
<tr>
<td>ERR06</td>
<td>Fire risk management</td>
<td>12</td>
<td>8</td>
<td>Beverley Murphy</td>
</tr>
<tr>
<td>ERR11</td>
<td>Overstays in the Health Based Place of Safety - s135-136 expiries</td>
<td>12</td>
<td>4</td>
<td>Kristin Dominy</td>
</tr>
<tr>
<td>ERR12</td>
<td>Mental Health Act Compliance</td>
<td>12</td>
<td>3</td>
<td>Beverley Murphy</td>
</tr>
<tr>
<td>ERR17</td>
<td>Failure to meet Mental Health Tribunal requirements - late reports</td>
<td>12</td>
<td>9</td>
<td>Beverley Murphy</td>
</tr>
<tr>
<td>ERR31</td>
<td>Data loss</td>
<td>12</td>
<td>8</td>
<td>Gus Heafield</td>
</tr>
<tr>
<td>ERR07</td>
<td>Prescribing errors</td>
<td>10</td>
<td>10</td>
<td>Michael Holland,</td>
</tr>
<tr>
<td>ERR08</td>
<td>Delayed Mental Health Act Assessments</td>
<td>9</td>
<td>6</td>
<td>Kristin Dominy</td>
</tr>
<tr>
<td>ERR09</td>
<td>Risk assessment &amp; care plans</td>
<td>9</td>
<td>9</td>
<td>Kristin Dominy</td>
</tr>
<tr>
<td>ERR23</td>
<td>Capacity/ commitment for Partnership working</td>
<td>9</td>
<td>9</td>
<td>Altaf Kara</td>
</tr>
</tbody>
</table>

Table 2 lists ERR risks not currently on the BAF.

5. Action
The Board is requested to note and approve the changes to the BAF.
**Principal Risk 7 (Quality & statutory compliance):** In the context of significant demand, change and unpredictable clinical situations and following the initial feedback from the CQC from the July 2018 inspection there is a potential risk that the trust will fail to deliver the necessary regulatory actions (must do’s and regulation 29A warning notice) and quality improvements identified by the CQC or meet our other regulatory duties and therefore create a risk of breaching regulation and/or statutory duties.

<table>
<thead>
<tr>
<th>Owner:</th>
<th>BM / DoN</th>
</tr>
</thead>
<tbody>
<tr>
<td>Committee:</td>
<td>Quality committee</td>
</tr>
<tr>
<td>Proximity:</td>
<td>12 months</td>
</tr>
<tr>
<td>Risk Category:</td>
<td>Quality (patient safety, experience &amp; clinical outcomes)</td>
</tr>
<tr>
<td>Risk Appetite:</td>
<td>Cautious (nominal range 3-8)</td>
</tr>
</tbody>
</table>

**Potential Causes (links to the CRR)**

The context of consistent delivery of mental health services across four London Boroughs; significant need and deprivation; a time of unprecedented NHS financial challenge; current levels of funding is amongst the lowest in the country; the transformation of services creates significant pressure for people leading services and people delivering services. This challenges the capacity and capability of an organisation to make change and improvements.

**Key Controls**

Internal: Established, well led Board of Directors, experienced Service and Clinical Directors, clear operational and professional structure, quality governance, operational performance management, recruitment of sufficient high quality staff. Good knowledge or regulatory standards. CQC PID, action plan and core planning meeting in place. Monthly Operational Directorate Quality Governance Compliance meeting embedded. Risk management strategy and incident reporting structure in place. Established health safety and fire management procedures and governance arrangements. Ligature anchor point audit and management procedures and annual risk reduction programme. CQC preparation meetings. Borough Directors (fresh set of eyes) full site visits. SMT quality visits (to all sites within the year).

Significant mitigations in place to address issues accessing beds (MADE etc).

External: established relationships with commissioners, full engagement with alliance boards, engagement / leadership of transformation programmes (locally and nationally). CQRG clinical quality review group chaired by CCG.

**Sources of Assurance**

COO Quality report, Learning lessons reports, compliance reports, CQUINN reports, progress reports of delivery of CQC inspection improvement actions, QUEST scores, safer staffing reviews, QI progress reports, reported progress on delivery of strategy, monthly quality compliance committees with Operational Directorates embedded and Quality matters governance meetings embedded.

**Potential Consequences**

Services and staff become overly focussed in maintaining status quo and do not have the capacity to improve and transform. In the current context this could lead to an adverse impact on quality of care which ultimately could lead to the trust failing to meet the required improvement actions (Must do / Should do) as set out in inspection reports. This could lead to regulatory action and loss of services.

**Gaps in Control**

Short of staff in some areas (e.g. CPNs). Governance framework and outcome measures agreed as part of Alliance development but not yet fully tested in practice. Not all Boroughs have recruited a full senior management team. Southwark Head of Nursing not yet recruited. Inconsistent completion of physical healthcare checks following rapid tranquillisation. Inconsistent implementation of standards of care & quality governance across Acute pathway. Bottlenecks, obstacles & lack of agreed processes/protocols and clarity on pathway, flow and discharge management. Gaps in governance leading to problems with 'floor to Board' oversight of risks.

**Gaps in Assurance**

QI methodology is starting to build however the approach is new and will take time to embed. Data Quality, compatibility & integrated report issues being addressed by data summit. Transition of quality governance information into a format reflecting the new borough structures not yet completed. Evidence of failures in local governance arrangements to ensure incidents/reports are escalated appropriately (e.g. ward report of beds not being available for patients returning from leave or CTOs not being appropriately escalated).
The Board has overall responsibility for ensuring systems and controls are in place, sufficient to mitigate any significant risks which may threaten the achievement of the strategic objectives. Assurance may be gained from a wide range of sources, but where ever possible it should be systematic, supported by evidence, independently verified, and incorporated within a robust governance process. The Board achieves this, mainly through the work of its Assurance committees, through use of Audit and other independent inspection and by systematic collection and scrutiny of performance data, to evidence the achievement of the objectives.
<table>
<thead>
<tr>
<th>Lead Director Ref No.</th>
<th>Subject</th>
<th>Principal Risk</th>
<th>Initial score</th>
<th>Sep</th>
<th>Dec</th>
<th>Mar</th>
<th>June</th>
<th>Sep</th>
<th>Dec</th>
<th>Trend</th>
<th>Target score</th>
<th>Gap</th>
</tr>
</thead>
<tbody>
<tr>
<td>HRD 1</td>
<td>Workforce</td>
<td>If the trust can not attract, recruit and retain enough highly skilled staff, in the right settings with the ability to respond to organisational change the risk is that the quality of care may not be acceptable or consistent across services.</td>
<td>12</td>
<td>12</td>
<td>12</td>
<td>12</td>
<td>20</td>
<td>20</td>
<td></td>
<td>&lt;&gt;</td>
<td>8</td>
<td>12</td>
</tr>
<tr>
<td>KD 2</td>
<td>Operational delivery structure</td>
<td>If the trust does not deliver services from an effective operational structure, have clear care pathways and clinically driven care protocols there is a risk that there will be delays in care and that transfers between services will adversely impact the quality of care and service user experience.</td>
<td>16</td>
<td>16</td>
<td>16</td>
<td>20</td>
<td>16</td>
<td>16</td>
<td></td>
<td>&lt;&gt;</td>
<td>6</td>
<td>10</td>
</tr>
<tr>
<td>KD 3</td>
<td>Informatics</td>
<td>Failure to develop Trust informatics systems could adversely impact the quality of care, staff experience and our ability to meet contract requirements.</td>
<td>12</td>
<td>12</td>
<td>12</td>
<td>12</td>
<td>12</td>
<td>12</td>
<td></td>
<td>&lt;&gt;</td>
<td>6</td>
<td>6</td>
</tr>
<tr>
<td>BM 5</td>
<td>Partnership working with service users</td>
<td>If the Trust fail to listen to the experience of people that use services and / or fail to implement the learning from all sources of adverse incidents there is a risk that services will not learn, not improve safety and present unacceptable risks for people that use services.</td>
<td>15</td>
<td>12</td>
<td>12</td>
<td>12</td>
<td>12</td>
<td>12</td>
<td></td>
<td>&lt;&gt;</td>
<td>6</td>
<td>6</td>
</tr>
<tr>
<td>BM 7</td>
<td>Quality &amp; statutory compliance</td>
<td>In the context of significant demand, change and unpredictable clinical situations there is a potential risk that the trust will fail to deliver the necessary regulatory actions (must do’s) and quality improvements identified by the CQC or meet our other regulatory duties and therefore create a risk of breaching regulation and/or statutory duties.</td>
<td>12</td>
<td>8</td>
<td>8</td>
<td>8</td>
<td>8</td>
<td>16</td>
<td></td>
<td>&lt;&gt;</td>
<td>8</td>
<td>8</td>
</tr>
<tr>
<td>GH 8</td>
<td>Finance contracts</td>
<td>If new contract values and the transitions to new contracts do not provide sufficient financial resource to deliver high quality clinical care there is a risk that the trust will not be able to provide timely access to safe high quality services across all Boroughs and care pathways</td>
<td>15</td>
<td>15</td>
<td>15</td>
<td>15</td>
<td>12</td>
<td>12</td>
<td></td>
<td>&lt;&gt;</td>
<td>9</td>
<td>3</td>
</tr>
<tr>
<td>AK 9</td>
<td>Estates</td>
<td>The Trust estate strategy will be delivered over the next 5 years and is dependent on significant capital investment. During the five years services will continue to be delivered from buildings of differing age, quality and standards and there is a risk that the experience of staff and patients is adversely affected and that safety is compromised. Furthermore, there is a risk that developments will be unfit for purpose, delivery of major new buildings will be delayed or go over budget.</td>
<td>20</td>
<td>16</td>
<td>16</td>
<td>16</td>
<td>16</td>
<td>16</td>
<td></td>
<td>&lt;&gt;</td>
<td>9</td>
<td>7</td>
</tr>
<tr>
<td>MH 11</td>
<td>QI delivery</td>
<td>There is a risk that the significant time, resource and money that the trust has invested in quality improvement will not result in the improvements in quality and efficiency of services that is anticipated.</td>
<td>9</td>
<td>9</td>
<td>9</td>
<td>9</td>
<td>12</td>
<td>12</td>
<td></td>
<td>&lt;&gt;</td>
<td>6</td>
<td>6</td>
</tr>
<tr>
<td>GH 12</td>
<td>Finance (cost management)</td>
<td>If services and departments do not deliver within their budgets, do not deliver the planned cost improvements, QIPPs and CQUINs and if we do not manage within Trust capacity the risk is that costs are uncontrolled and that the financial position of the Trust is destabilised which will prompt intervention by the Regulators.</td>
<td>15</td>
<td>15</td>
<td>15</td>
<td>15</td>
<td>12</td>
<td>12</td>
<td></td>
<td>&lt;&gt;</td>
<td>12</td>
<td>0</td>
</tr>
<tr>
<td>HRD 13</td>
<td>Mandatory training</td>
<td>If the Trust fails to meets its mandatory training compliance targets as a result of poor local management oversight, data quality or availability of courses, there is a risk to staff and patient safety and of breaching regulation of the local training gaps with a risk to the safety of staff and patients</td>
<td>20</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
<td>12</td>
<td>12</td>
<td></td>
<td>&lt;&gt;</td>
<td>4</td>
<td>8</td>
</tr>
</tbody>
</table>
# Heat map showing current risk rating of principal risks

<table>
<thead>
<tr>
<th>Consequence score</th>
<th>Likelihood score</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>1</td>
</tr>
<tr>
<td>Rare</td>
<td>Unlikely</td>
</tr>
</tbody>
</table>

## Current BAF risk
- **5** Catastrophic
- **4** Major
- **3** Moderate
- **2** Minor
- **1** Negligible

## New BAF risk

- **8**
- **11**
- **13**

- **3**
- **5**
- **7**
- **2**
- **9**
- **1**

*Current BAF risk - the number relates to the principal risk number*

*New BAF risk - the number relates to the principal risk number*
## Overall aim
To support the continuous improvement of the mental health outcomes for the people and communities we serve whilst maintaining financial stability

## Changing Lives ambitions [Primary Drivers]

<table>
<thead>
<tr>
<th>Supporting broader communities as well as individuals</th>
<th>Changing Lives ambitions [Secondary drivers]</th>
</tr>
</thead>
<tbody>
<tr>
<td>Relentless focus on quality of care, experience and outcomes.</td>
<td>CL1: Deliver outstanding care and experience every day from high-quality estate, placing quality improvement at the heart of everything we do.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Enabling staff to make full use of research, development and innovation</th>
</tr>
</thead>
<tbody>
<tr>
<td>CL2: Partnership working with our service users, their families and carers in the development and delivery of services</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Making the best use of our money, and supporting vital information infrastructure</th>
</tr>
</thead>
<tbody>
<tr>
<td>CL3: Improve how we value, develop, involve and empower our staff</td>
</tr>
</tbody>
</table>

## Quality Priorities

<table>
<thead>
<tr>
<th>Quality Priorities</th>
</tr>
</thead>
<tbody>
<tr>
<td>All patients will have access to the right care, at the right time, in the appropriate setting</td>
</tr>
<tr>
<td>We will reduce violence by 50% over 3 years with the aim of reducing all types of restrictive practice</td>
</tr>
<tr>
<td>Within 3 years we will routinely involve service users and carers in (a) all aspects of service design, improvement and governance, and (b) all aspects of the planning and delivery of their loved ones’ care</td>
</tr>
<tr>
<td>Over the next 3 years, we will enable staff to enjoy improved satisfaction and joy at work</td>
</tr>
</tbody>
</table>

## Enabling staff to make full use of research, development and innovation

<table>
<thead>
<tr>
<th>Enabling staff to make full use of research, development and innovation</th>
</tr>
</thead>
<tbody>
<tr>
<td>CL4: Move to whole population contracts in all our boroughs, to deliver better population outcomes, starting with the Lambeth Alliance</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Enabling staff to make full use of research, development and innovation</th>
</tr>
</thead>
<tbody>
<tr>
<td>CL5: Work with our partners in Oxleas and SWLStG to improve the delivery and reach of our national and specialist services.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Enabling staff to make full use of research, development and innovation</th>
</tr>
</thead>
<tbody>
<tr>
<td>CL6: Improve the translation of research into clinical practice – including physical and mental health – and develop a successful fundraising campaign, including CYP</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Enabling staff to make full use of research, development and innovation</th>
</tr>
</thead>
<tbody>
<tr>
<td>CL7: Ensure we are financially sustainable and governed to the highest possible standards</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Enabling staff to make full use of research, development and innovation</th>
</tr>
</thead>
<tbody>
<tr>
<td>CL8: Develop profitable commercial ventures that will enable us to further support and invest in our local services</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Enabling staff to make full use of research, development and innovation</th>
</tr>
</thead>
<tbody>
<tr>
<td>CL9: Enable staff to make the best use of information with reliable IT infrastructure and applications</td>
</tr>
</tbody>
</table>
**Risk Appetite Statement March 2018**

“The Board of Directors has developed and agreed the principles of risk that the Trust is prepared to accept, deal and tolerate whilst in pursuit of its objectives. The Board has a broadly cautious to open approach to risk but actively encourages well-managed and defined risk management, in alignment with its risk strategy, acknowledging that service development, innovation and improvements in quality require a level of risk taking.

Our lowest risk appetite relates to regulatory compliance but we have greater risk appetite for innovation, commercial and partnership strategies. This means that we will ensure we prioritise the minimisation of risks relating to our legal obligations whilst seeking opportunities to develop and enhance the quality and efficiency of our service delivery.”

The following draft principles outline the Board’s appetite for risk further:

<table>
<thead>
<tr>
<th>Risk category</th>
<th>Specific risk appetite statement</th>
<th>Risk Appetite level[1]</th>
<th>Indicative risk rating range for the risk appetite</th>
</tr>
</thead>
<tbody>
<tr>
<td>Quality (patient safety, experience &amp; clinical outcomes)</td>
<td>The Board is committed to delivering outstanding care and services including achieving CQC ‘Outstanding’ and will adopt a cautious approach to risk where the benefits are justifiable and the potential for mitigating actions are strong</td>
<td>Cautious</td>
<td>3 - 8</td>
</tr>
<tr>
<td>Finance</td>
<td>The Board has a cautious risk appetite for risk that may affect our aim to be financially sustainable and governed to the highest possible standards. However we have an open risk appetite to investing or allocating resources that may capitalise on opportunities for generating longer term return</td>
<td>Cautious to open</td>
<td>3 - 10</td>
</tr>
<tr>
<td>Operational performance</td>
<td>The Board is committed to maintaining and improving performance against core standards and will adopt a cautious approach to risks that may adversely affect this aim</td>
<td>Cautious</td>
<td>3 - 8</td>
</tr>
<tr>
<td>Strategic change &amp; innovation</td>
<td>The Board has a high risk appetite for strategic change, innovation, partnerships and commercial ventures that will develop our clinical &amp; operational service delivery</td>
<td>Open-seeking</td>
<td>6 - 15</td>
</tr>
<tr>
<td>Regulation &amp; Compliance</td>
<td>The Board has a minimal to cautious risk appetite when it comes to compliance and regulatory issues (including financial obligations). The Board will make every effort to meet statutory regulations and standards, unless there is compelling evidence or argument to challenge them</td>
<td>Minimal-Cautious</td>
<td>1 - 8</td>
</tr>
<tr>
<td>Workforce</td>
<td>The Board has a cautious approach to risks that may affect our commitment to value, develop, involve and empower our staff</td>
<td>Cautious</td>
<td>3 - 8</td>
</tr>
<tr>
<td>Reputational</td>
<td>The Board has a cautious to open approach for risks that may affect the Trust’s reputation. On occasions we may be accept risks where there are potential benefits to delivering our quality priorities</td>
<td>Cautious - open</td>
<td>3 - 10</td>
</tr>
</tbody>
</table>

### Principal Risk 1 (Workforce): If the trust can not attract, recruit and retain enough highly skilled staff, in the right settings with the ability to respond to organisational change the risk is that the quality of care may not be acceptable or consistent across services.

<table>
<thead>
<tr>
<th>Owner:</th>
<th>HR Director</th>
</tr>
</thead>
<tbody>
<tr>
<td>Committee:</td>
<td>Equalities &amp; Workforce Committee</td>
</tr>
<tr>
<td>Proximity:</td>
<td>Immediate</td>
</tr>
<tr>
<td>Risk Category:</td>
<td>Workforce</td>
</tr>
<tr>
<td>Risk Appetite:</td>
<td>Cautious (nominal range 3-8)</td>
</tr>
</tbody>
</table>

#### Potential Causes (links to the CRR)
- National shortage of suitably qualified staff and numbers reducing in some key staff groups.
- High cost of living in London.
- Several years of pay restraint.
- Brexit.
- Increasing pressure of work.
- Staff not always attracted into this area of work.
- Staff morale & retention negatively impacted by Borough re-structure.
- Staff engagement negatively impacted by implementation of iCare.
- Escalating patient acuity negatively impacts on staff morale.

#### Potential Consequences
- Patient care affected by staff shortages, poor patient experience, poor staff experience, higher bank usage and higher agency spend.

#### Key Controls
- Retention and recruitment strategy actions including getting the basics right, improving recruitment processes, improving staff engagement, enhancing the development and training offer and redesigning roles.
- Talent management programme, targeted recruitment campaigns.
- SLP nurse development and workforce programme.
- BME development and support network strategy.
- Guaranteed job offers for student nurses.
- Working Race Equalities Scheme and Equalities and Workforce Action Plan.
- Increased support for development opportunities.
- Addition of new roles for workforce.
- Staff engagement plan.
- Borough re-structure delivered.
- iCare implementation risk mitigation plan.
- Positive outcomes from the implementation of iCare.
- Trust wide preceptorship scheme.
- Improvements to e-appraisal.
- Leadership engagement plan.
- Participation in NHSI retention strategy.

#### Sources of Assurance
- Quarterly workforce & equalities action plan progress report.
- Recruitment and retention KPIs, annual national staff survey, quarterly staff friends and family test.
- Deep dive reports eg to CCG.
- Quarterly workforce & equalities action plan progress report.

#### Assurance on the effectiveness of Controls
- SMT will ensure assurance is maintained during the critical phase of the change management programme by taking every opportunity to engage with staff during the planned quality visits and review weekly as part of the Monday morning SMT QI meeting.

#### Request for Closure
- No

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<table>
<thead>
<tr>
<th>Inherent</th>
<th>Sep 17</th>
<th>Dec 17</th>
<th>Mar 18</th>
<th>Jun-18</th>
<th>Sep-18</th>
</tr>
</thead>
<tbody>
<tr>
<td>Trend</td>
<td>0</td>
<td>10</td>
<td>20</td>
<td>8</td>
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<table>
<thead>
<tr>
<th>Owner:</th>
<th>HR Director</th>
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</thead>
<tbody>
<tr>
<td>Committee:</td>
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<td>Immediate</td>
</tr>
<tr>
<td>Risk Category:</td>
<td>Workforce</td>
</tr>
<tr>
<td>Risk Appetite:</td>
<td>Cautious (nominal range 3-8)</td>
</tr>
</tbody>
</table>

#### Likelihood
- Initial: 4
- Current: 5
- Target: 2

#### Consequence
- Initial: 3
- Current: 4
- Target: 4

#### Level
- Initial: 12
- Current: 20
- Target: 8

#### Last reviewed
- Jun-18

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#### Gaps in Control
- Operational impacts from lack of vacancy data at ward level.
- High and continuous agency staff usage in some areas eg CPNs.
- Lack of robust housing strategy.
- Impacts of aligning agency rates to NHS pay levels yet to be assessed.
- Talent management programme labour intensive and pilot yet to deliver desired outcomes.
- Developments in supervision.
- Lack of a robust and fully representative staff side bringing trade union and professional association scrutiny to what we do.

#### Gaps in Assurance
- Recruitment & retention KPIs currently limited to Operational Directorate level.

#### Action plan progress summary
- Single Equalities & Workforce Action Plan in place drawing together all relevant actions, with identified lead responsibilities, timescales, and RAG rated progress.
- Q3 – overall status assessment rating green (no red rated actions, 32 amber, 62 green).
- Mandatory training action plan to be incorporated in next quarterly update.
- Staff survey action plan updated to reflect 2017 results.
**Principal Risk 2 (Operational delivery structure):** If the trust does not deliver services from an effective operational structure, have clear care pathways and clinically driven care protocols there is a risk that there will be delays in care and that transfers between services will adversely impact the quality of care and service user experience.

<table>
<thead>
<tr>
<th>Owner:</th>
<th>MH/MD; BM/DoN &amp; KD/COO</th>
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</thead>
<tbody>
<tr>
<td>Committee:</td>
<td>Quality committee</td>
</tr>
<tr>
<td>Proximity:</td>
<td>Immediate</td>
</tr>
<tr>
<td>Risk Category:</td>
<td>Operational Performance</td>
</tr>
<tr>
<td>Risk Appetite:</td>
<td>Cautious to open (nominal range 3-10 )</td>
</tr>
</tbody>
</table>

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<tr>
<th></th>
<th>Initial</th>
<th>Current</th>
<th>Target</th>
</tr>
</thead>
<tbody>
<tr>
<td>Likelihood</td>
<td>4</td>
<td>4</td>
<td>3</td>
</tr>
<tr>
<td>Consequence</td>
<td>Level</td>
<td>4</td>
<td>4</td>
</tr>
</tbody>
</table>

**Potential Causes (links to the CRR)**

The design of borough teams and their functioning has become more complex in recent years, reflecting a genuine pursuit of quality through specialism but with a number of unintended consequences. Teams working in new alliance structures and with non SLaM staff are not supported by clear and robust clinical governance frameworks and protocols.

**Potential Consequences**

Board to Ward decision-making can therefore be protracted reducing the effectiveness of the operational structure.

Patients experience can be impacted by hand-offs between teams

Performance across boroughs, services and teams differs and quality can be inconsistent. Delays are caused as a result of the lack of a standardised approach.

Impact on quality and safety in services delivered through alliance contracts, and reputational risk for the Trust

**Key Controls**

The iCare QI programme is designed to reduce variation in operational practices, improve patient outcomes and experience, enhance staff experience and also improve interfaces with external stakeholders. The programme is now in progress with 4 main work streams and weekly iCare meetings including senior leaders from across the Trust.

A restructure to a Borough based model has been delivered.

All pre-existing CAG improvement plans have been realigned to the new Borough structures.

Performance templates have been redesigned to be Borough specific and a comprehensive redesign of governance structures is in progress.

Development of community QUESTT as a tool to enable performance monitoring and pre-emptive corrective action.

MADE events.

Qualitative audit programme of risk assessments.

Weekly key performance indicator reporting.

Right Care (CQC implementation) plans to implement and embed sustainable improvements to fundamental standards of care, governance, pathway flow, leadership & culture, quality enablers and communication.

**Gaps in Control**

Following the Trust re-structures to a borough model, the mitigation measures to ensure quality is not adversely affected have not been fully tested nor is evidence available to prove improvements to effective decision-making have been realised.

In relation to iCare, evidenced based outcomes are yet to be delivered.

Right Care (CQC implementation) plans yet to be finalised and commenced.
<table>
<thead>
<tr>
<th>Sources of Assurance</th>
<th>Gaps in Assurance</th>
</tr>
</thead>
</table>
| Performance monitoring KPIs through PACMAN (including DTOC, LoS and other throughput and quality measures such as patient experience). | QI Programme and Performance Management systems are not yet integrated and fully aligned.  
CQC implementation plan outcomes evidenced based outcomes are yet to be finalised. |
| CQC Review.                                                                        |                                                                                  |
| Clinical governance framework, monitoring and assurance processes built into Alliance contract with clear governance and assurance route to SLaM. |                                                                                  |
| Quality Portfolio Board & CQC implementation plan Delivery Board                    |                                                                                  |

<table>
<thead>
<tr>
<th>Assurance on the effectiveness of Controls</th>
<th>Action plan progress summary</th>
</tr>
</thead>
</table>
| Reports will be made available to QC and FPC for assurance and discussion.       | MADE events action plan in place with target of 2 events per Borough by March 2019.  
Right Care (CQC implementation) Governance structures in place. Terms of reference drafted and work stream design progressing. Implementation plans yet to be finalised and action commenced |

<table>
<thead>
<tr>
<th>Request for Closure</th>
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<tbody>
<tr>
<td>No</td>
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</table>
Principal Risk 3 (Informatics): Failure to develop Trust informatics systems could adversely impact the quality of care, staff experience and our ability to meet contract requirements.

*Owner:* KD / COO  
*Committee:* Finance and Performance Committee  
*Proximity:* Immediate  
*Risk Category:* Strategic change & innovation  
*Risk Appetite:* Open to seeking (nominal range 6 - 15)

<table>
<thead>
<tr>
<th></th>
<th>Initial</th>
<th>Current</th>
<th>Target</th>
</tr>
</thead>
<tbody>
<tr>
<td>Likelihood</td>
<td>3</td>
<td>3</td>
<td>2</td>
</tr>
<tr>
<td>Consequence</td>
<td>4</td>
<td>4</td>
<td>3</td>
</tr>
<tr>
<td>Level</td>
<td>12</td>
<td>12</td>
<td>6</td>
</tr>
</tbody>
</table>

**Potential Causes (links to the CRR)**

There are currently numerous independent systems responsible for different types of information across the Trust (workforce, clinical, financial, incidents, training etc.). Integrated reports are achieved through extensive manual manipulation and presentation of data and therefore there is variation between source data and reported data which is not reconciled.

A small number of systems are run from obsolete systems (Windows XP). The Power BI system cannot currently support statistical process control (SPC) reporting and a work around is being defined.

Increasingly, integrated care and partnership working is requiring information systems to cross organisational boundaries. There is discussion at STP level but not co-ordinated for LSLC.

Novel contracts have collapsed in other CCG areas due to poor data leading to unexpected financial risk.

The Trust informatics systems may not be accessible by all staff.

**Key Controls**

The independent systems all have differing reporting capabilities. The Power BI tool is being developed to be a single point of access for relevant information across the Trust. The implementation of Power BI enables all staff to have access to the information.

In February 2018, system owners met, chaired by COO and DoN, together to set out priorities to address the frustrations experienced by staff and therefore this risk. This forum has continued to meet on a monthly basis and it has enabled improved communication and agreement around priorities. Additionally, a central record of systems, their owners and inter-connections is being compiled.

Weekly information development meetings are led by the Deputy Medical Director for Informatics and Quality Improvement.

A new Service Directory has been designed to provide co-ordination and cross-referencing between systems to enable automatic reports to be produced without manual interference.

**Potential Consequences**

Production of inconsistent or irreconcilable data will damage the reputation of the organisation if challenged by external organisations and may also incorrectly reflect the clinical and quality standards being achieved. Incorrect information may also result in inferior decision-making for quality improvement initiatives.

Capital investment will be required to replace or eliminate systems at risk. Obsolete systems must be isolated to manage risk of cyber-attack. STP discussions to consider LSLC co-working.

There is a risk that initially the increased usage and closer scrutiny will highlight new problems with data sources and mapping. The focus on developing assurance and governance processes will support the rapid resolution of emerging problems.

Adopting cloud-based solutions reduces risk from local technical infrastructure outages. Digital Services needs work with BI to ensure accessibility throughout the organisation.

SPC remains as an outstanding need to allow the organisation understand its clinical variability.

**Gaps in Control**

The new monthly meeting of system owners will be formalised alongside the assurance reporting processes. The governance processes for the Service Directory are being developed and documented.

Formal information controls are not yet in place with the various owners of data sources: Finance, HR, Estates & Facilities, BI and Digital Services. This is being addressed May / June 2018.
### Sources of Assurance

A quarterly BI assurance report has been developed between the Head of Business Intelligence and the Head of Information Governance. This will be extended in 2018 to all systems and include data assurance and system support and management. QC oversight of IT developments & impacts on quality data collection.

### Sources of Assurance

<table>
<thead>
<tr>
<th>Assurance on the effectiveness of Controls</th>
</tr>
</thead>
<tbody>
<tr>
<td>Reports will be made available to the Global Digital Exemplar / Quality Improvement Programme Board and also Finance and Performance Committee for assurance and discussion.</td>
</tr>
</tbody>
</table>

### Gaps in Assurance

Close monitoring of the introduced information governance process will identify potential gaps.

### Gaps in Assurance

<table>
<thead>
<tr>
<th>Request for Closure</th>
</tr>
</thead>
<tbody>
<tr>
<td>COO to arrange Data Summit for September 2018 to review action plan progress</td>
</tr>
</tbody>
</table>

### Assurance on the effectiveness of Controls

<table>
<thead>
<tr>
<th>No</th>
</tr>
</thead>
</table>
**Principal Risk 5 (Partnership working with service users):** If the Trust fail to listen to the experience of people that use services and/or fail to implement the learning from all sources of adverse incidents there is a risk that services will not learn, not improve safety and present unacceptable risks for people that use services.

<table>
<thead>
<tr>
<th>Owner: BM / DoN</th>
<th>Initial</th>
<th>Current</th>
<th>Target</th>
</tr>
</thead>
<tbody>
<tr>
<td>Committee: Quality committee</td>
<td>3</td>
<td>3</td>
<td>3</td>
</tr>
<tr>
<td>Proximity: Immediate</td>
<td>5</td>
<td>4</td>
<td>2</td>
</tr>
<tr>
<td>Risk Category: Quality (patient safety, experience &amp; clinical outcomes)</td>
<td>15</td>
<td>12</td>
<td>6</td>
</tr>
<tr>
<td>Risk Appetite: Cautious (nominal range 3-8)</td>
<td>Jun-18</td>
<td>Next review</td>
<td>Sep-18</td>
</tr>
</tbody>
</table>

### Potential Causes (links to the CRR)

Culture that does not value engagement with people who use services. Lack of structure / framework to support service user engagement. Lack of confidence to move into co production with service users and carers. Reporting structures that are not open, failure to be open. Lack of analysis and reporting of adverse incidents. Information that is presented in a format that is difficult to use. QI methodology not applied. Delays in receiving conclusions of SI investigations. Delays in receiving conclusions of homicide reviews.

### Key Controls

Implementation of Patient and Public Involvement policy and plans with measurable outcomes across Trust services. Significant Involvement of service users and carers in Operational Directorate governance. Adherence to ‘Being Open’. Monitoring of the quality of complaints and SI reports is oversee by senior Operational and Executive Directors. Monthly Operational Directorate Quality Governance Compliance meeting embedded and includes PPI. Risk management strategy and incident reporting structure in place. Action plans developed and monitored to implement learning from adverse incidents. Trust wide SI panel to ensure learning is shared. Trust audit programme. Safety bulletins, events and Operational Directorate briefings. Quality priorities consultation with service user and cares. Patient voice at Board.

### Sources of Assurance

Learning lessons report to QSC and Board. Practice changes (locally and trust wide) as a result of adverse incidents. Reports on PPI strategy by Operational Directorates into the trust wide involvement committee. Oversight of the level 2 serious incident reports by the Medical and Nursing Director, closure of all SI reports by the CCGs. Oversight of CEO level complaint responses by Director of nursing. Oversight of all reported incidents by Service and Clinical Directors. Monthly quality compliance committees with Operational Directorates. External oversight via CRQG, deep dives by CCGs and NHSE oversight of delivery of homicide plans. Delivery and monitoring of action plans in relation to PFDs (rule 28). Care plan and risk assessment audits. Trust wide SI meeting and reports to Quality Committee and the Board detailing incidents of all kinds, where they happen, what the nature is and the level of investigation as well as an investigation progress status update.

### Potential Consequences

Failure to learn leading to unacceptable risks to safety for people that use services and a poor staff and service user experience. People who use, commission or regulate our service have a lack of confidence in the safety of our service.

### Gaps in Control

The risk will be better managed if all Operational Directorate and corporate services move from involvement to consistently co producing with people who use services. Additional rigor needed to ensure timeliness and accountability of delivery of action. Inequitable governance resources in existing CAG structures to be balanced in the Borough restructure. Consistency of learning across Trust.

### Gaps in Assurance

Services respond to risks and challenges on a daily basis, unless there is actual harm the near miss is not always reported and therefore shared as learning. Trends in learning need to be better understood and more effectively communicated in order to support change. QI methodology being used routinely. Not all CAGs have an embedded service user and carer involvement methodology. Weak performance levels for offering Carer Engagement and Support plans.
<table>
<thead>
<tr>
<th>Assurance on the effectiveness of Controls</th>
</tr>
</thead>
<tbody>
<tr>
<td>Combination of oversight of PPI implementation plans at trust wide level; Clinical Directors being held to account for delivery of improvement plans internally and by the CCG; clear escalation framework for all incidents reported and closure of complaints offers reasonable assurance.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Action plan progress summary</th>
</tr>
</thead>
<tbody>
<tr>
<td>PPI outcome framework metrics developed. Governance teams now allocated to Boroughs. Deputy Director of Nursing leading review. Report due end of July. Borough/local level introduction of SNAP audit system and My Team Dashboards have improved the audit and review process for assurance of the quality. Service users and carers Quality improvement methodology training. Recruitment commencing of two people with lived experience in the QI team. BI working on disaggregating Carer Engagement and Support plans data between inpatient and community teams. Tailored approach in place for CAMHS to reflect differed nature and needs of carers for young service users.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Request for Closure</th>
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</thead>
<tbody>
<tr>
<td>No</td>
</tr>
</tbody>
</table>
Principal Risk 7 (Quality & statutory compliance): In the context of significant demand, change and unpredictable clinical situations and following the initial feedback from the CQC from the July 2018 inspection there is a potential risk that the trust will fail to deliver the necessary regulatory actions (must do’s and regulation 29A warning notice) and quality improvements identified by the CQC or meet our other regulatory duties and therefore create a risk of breaching regulation and/or statutory duties.

<table>
<thead>
<tr>
<th>Owner:</th>
<th>Initial</th>
<th>Current</th>
<th>Target</th>
</tr>
</thead>
<tbody>
<tr>
<td>Committee:</td>
<td>BM / DoN</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Proximity:</td>
<td>12 months</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Risk Category:</td>
<td>Quality (patient safety, experience &amp; clinical outcomes)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Risk Appetite:</td>
<td>Cautious (nominal range 3-8)</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

### Potential Causes (links to the CRR)

The context of consistent delivery of mental health services across four London Boroughs; significant need and deprivation; a time of unprecedented NHS financial challenge; current levels of funding is amongst the lowest in the country; the transformation of services creates significant pressure for people leading services and people delivering services. This challenges the capacity and capability of an organisation to make change and improvements.

### Key Controls

**Internal:** Established, well led Board of Directors, experienced Service and Clinical Directors, clear operational and professional structure, quality governance, operational performance management, recruitment of sufficient high quality staff. Good knowledge or regulatory standards. CQC PID, action plan and core planning meeting in place. Monthly Operational Directorate Quality Governance Compliance meeting embedded. Risk management strategy and incident reporting structure in place. Established health safety and fire management procedures and governance arrangements. Ligature anchor point audit and management procedures and annual risk reduction programme. CQC preparation meetings. Borough Directors (fresh set of eyes) full site visits. SMT quality visits (to all sites within the year). Significant mitigations in place to address issues accessing beds (MADE etc).

**External:** established relationships with commissioners, full engagement with alliance boards, engagement / leadership of transformation programmes (locally and nationally). CQRG clinical quality review group chaired by CCG

### Potential Consequences

Services and staff become overly focussed in maintaining status quo and do not have the capacity to improve and transform. In the current context this could lead to an adverse impact on quality of care which ultimately could lead to the trust failing to meet the required improvement actions (Must do / Should do) as set out in inspection reports. This could lead to regulatory action and loss of services.

### Sources of Assurance

COO Quality report, Learning lessons reports, compliance reports, CQUINN reports, progress reports of delivery of CQC inspection improvement actions, QUEST scores, safer staffing reviews, QI progress reports, reported progress on delivery of strategy, monthly quality compliance committees with Operational Directorates embedded and Quality matters governance meetings embedded.

### Gaps in Control

Short of staff in some areas (e.g. CPNs). Governance framework and outcome measures agreed as part of Alliance development but not yet fully tested in practice. Not all Boroughs have recruited a full senior management team. Southwark Head of Nursing not yet recruited. Inconsistent completion of physical healthcare checks following rapid tranquillisation. Inconsistent implementation of standards of care & quality governance across Acute pathway. Bottlenecks, obstacles & lack of agreed processes/protocols and clarity on pathway, flow and discharge management. Gaps in governance leading to problems with 'floor to Board' oversight of risks.

### Gaps in Assurance

QI methodology is starting to build however the approach is new and will take time to embed. Data Quality, compatibility & integrated report issues being addressed by data summit. Transition of quality governance information into a format reflecting the new borough structures not yet completed. Evidence of failures in local governance arrangements to ensure incidents/reports are escalated appropriately (e.g. ward report of beds not being available for patients returning from leave or CTOs not being appropriately escalated).
### Assurance on the effectiveness of Controls

CQC compliance inspection reports had provided good assurance that controls are effective however the recent QCC inspection (July-August 2018) has highlighted concerns systems are not fully embedded or care consistently applied thought out the Trust.

### Action plan progress summary

Trust wide improvement plans being developed following July – August 2018 CQC inspection. Implementation governance structures being developed to support implementation and evidence embedded progress and outcomes.

### Request for Closure

No
**Principal Risk 8 (Finance - contracts):** If new contract values and the transitions to new contracts do not provide sufficient financial resource to deliver high quality clinical care there is a risk that the trust will not be able to provide timely access to safe high quality services across all Boroughs and care pathways.

<table>
<thead>
<tr>
<th>Owner</th>
<th>Initial</th>
<th>Current</th>
<th>Target</th>
<th>Trend</th>
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<td>3 months.</td>
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<tr>
<td>Finance</td>
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<tr>
<td>Cautious to open (nominal range 3-10)</td>
<td></td>
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<td></td>
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<tr>
<td>Jun-18</td>
<td>Next review</td>
<td>Sep-18</td>
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</tbody>
</table>

**Potential Causes (links to the CRR)**

There is a risk that due to the on-going and severe financial pressures in the NHS, South London Health Economy and SEL STP contract values will be offered and set at levels that would put patient care at risk. Currently, the key CCGs for SLaM (Lambeth, Southwark, Lewisham and Croydon) are all funded in the lowest quartile in terms of spend per weighted population. This inequity in funding increases the likelihood of suboptimal financial settlements. Additional risk will also stem from the variability of financial health across the key commissioning boroughs (with Croydon as a particular concern). Significant risk will also stem from the uncertainty around the development of new commissioning arrangements (e.g. alliances) in which SLaM will need to increasingly compete to maintain a fair financial settlement for its service users. Similar uncertainty around risk / opportunity will also be reflected whilst the SLP finalises the financial arrangements around forensics, CAMHs and any other future partnership programmes.

**Key Controls**

Dedicated and focused contracting and finance resource to assess financial sustainability implications and terms. Clear quality assurance procedures (e.g. QIAs) to assess and validate impact of any new contracts on patient care. Contracts to be sanctioned by FPC, SMT and the Board. The trust has an established QI process and PMO function in order to ensure a focus remains on delivering maximum value for patients to ensure limited funds are spent effectively and strengthening the Trust’s bargaining position. The Trust has developed a “Red Lines” analysis to assess material projects including alliances. There is a specific section relating to financial matters. Failure to score 6 out of 10 flags the issue as a ‘red line’ and if not mitigated would stop the project from progressing.

**Gaps in Control**

The pace of change and breadth of scope of the new contracting and commissioning arrangements coupled with the uncertainty and complexity of new models will create capacity pressures across all the relevant control mechanisms in the Trust. Challenging regulator deadlines create additional pressure and limit development time. The Trust will need to develop new finance and activity models to help mitigate these risks. A 3 to 5 year model is in development but is not yet complete. This will allow the Board to more readily assess the future state scenarios for the Trust. Any new contracts will require detailed risk share and escalation protocols in order to mitigate the risks to patient care. The Trust will need to influence the wider health system to ensure underfunding in our key boroughs and parity of esteem remain high up on the agenda at NHSI and the DH assurance. Lack of established communication routes with CCG to raise concerns of funding reductions on caseload and quality.

**Quality:** Material financial reductions in the Trust’s contracts will have a number of impacts that will directly impact patient care, experience and safety.

**Access/Activity:** Reduced funding will limit the number of patients the Trust can treat and/or the quality of care that can be provided. Indeed, to avoid patient safety issues the trust may be forced to withdraw from services altogether reducing access to the local population.

**Capacity (Clinical):** Staffing as resources (especially clinical and nursing staffing) would be severely constrained if funding is limited.

**Capacity (Management):** Increasing financial constraints will also consume managerial capacity within the trust and limit the focus on maximising quality.

**Financial:** Limited funding will have a negative impact on the trust’s cash position and would constrain its ability to invest in estate, equipment and technology to ensure they remain fit for purpose and offer the best value for money.
### Sources of Assurance

Contract settlements that align with STP and Trust based business planning requirements. FPC and SMT scrutiny of key contract arrangements and changes. Clear quality impact assessments detailing the implications and mitigations of any contract changes. Internal assurance is provided via audit and benchmarking to ensure SLaM offers excellent Value for Money. This would include; reference costs, Model Hospital, NHS Benchmarking and the trust’s internal ‘Red Lines’ analysis. The Trust has secured agreement on the Mental Health Investment Standard in 2018/19 with all Commissioners. There is still moderate risk as how the additional funding will be spent is still to be determined in some cases. The Trust has established Risk shares in place around inpatient bed days. £1.5m (net) additional funding has been secured from Southwark around Complex placements based on projected outturn. However, there remains some risk related to Southwark CCG no longer underwriting Placements funded by Southwark council. QIPPs requiring specific cost reductions have been limited to circa £1.5m in 2018/19 (as opposed to circa £10m in 2017/18). In addition, none of these QIPPs are related to bed reductions. The South London Mental Health Partnership has continued to develop New Models of Care yielding benefits in Forensics and Tier 4 CAMHS. Significant progress has been made in mitigating the financial and governance risks of the Lambeth Living Well Network Alliance and this is due to go live 1st July 2018. (see also BAF Risk 6 on Alliances).

### Gaps in Assurance

Comparators and Benchmarks around performance and best practice are limited or unavailable (e.g. the Model Hospital is still in development). Financial Modelling of new contractual models and impact of individual Borough approaches including partnership collaborative agreements need to be completed and assessed including Lambeth Living Well Network and Croydon Alliance.

### Assurance on the effectiveness of Controls

Clear contracting and business planning procedures assured by internal audit and NHSI sign off as the regulator. FPC, SMT and Board scrutiny and sign off of any new contracts. ISAP process for Alliance agreements conducted by NHSI / NHSE.

### Action plan progress summary

- Delivery action plan to be drafted with Head of Contracts and Performance (Rod Booth).
- Contracting action plan to be drafted with Head of Contracts and Performance (Rod Booth).
- Metrics under development.

### Request for Closure

No
Principal Risk 9 (Estates): The trust estate strategy will be delivered over the next 5 years and is dependent on significant capital investment. During the five years services will continue to be delivered from buildings of differing age, quality and standards and there is a risk that the experience of staff and patients is adversely affected and that safety is compromised. Furthermore, there is a risk that developments will be unfit for purpose, delivery of major new buildings will be delayed or go over budget.

<table>
<thead>
<tr>
<th>Owner: AK / DoSC</th>
<th>Committee: Finance and Performance Committee; SMT</th>
<th>Likelihood</th>
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<th>Target</th>
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<tr>
<td></td>
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<td>Risk Appetite</td>
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### Potential Causes (links to the CRR)

The capital funding allocated through the plan will not allow us to make sufficient improvements to all parts of the estate that needs it urgently quickly enough. We do not prioritise effectively, which is impacted on further by a lack of clinical and operational engagement. We may be unaware of risks that materialise as these are not reported through to the estates team – particularly in the community estates where we are tenants. Improvements we make are poorly executed or exacerbate further some of the existing problems/issues with the building environment. We are unable to execute the strategy of moving to integrated community hubs. We do not strengthen the capital projects team sufficiently or quickly.

### Key Controls

- Monitoring of achievement against demanding targets for responsiveness - particularly for statutory and urgent needs and progression capital and strategic projects in the CEF Executive meeting with the Director of Strategy & Commercial. Six facet survey on maintenance needs identifies the areas of concern and those areas to be prioritised for works for owned estate.
- The Estates Team ensure robust systems and processes are in place to monitor the condition of the estate and reportable incidents (Planet FM; Datix). Follow through of escalation processes into corporate risk registers. Continuous health and safety workplace assessments, including for those buildings where the service is occupying a building under third party ownership.
- Reports on the implementation of the action plan from SLaM internal audit reports of estate and property and capital processes. Ligature anchor pint assessment and associated work plan implementation and regularly assessed in conjunction with operational and clinical colleagues.

### Sources of Assurance

- Quarterly reports around the performance of the Estates and Facilities team will be provided to the Finance and Performance Committee and the Trust Board. Issues based updates to the Quality Committee on specific concerns relating to services or functions. Topic based updates to the Audit Committee based on commissioned reports.

### Assurance on the effectiveness of Controls

- Internal audit reports of estate and property and capital processes commissioned by the Director of Capital, Estates and Facilities.

### Potential Consequences

The patient experience is poor in buildings that are not fit for purpose and/or have poor environments. Health and safety issues raised both internally and externally if not dealt with could impact on our staff, patients and carers, and potentially cause harm. The Trust receives a “regulatory action” from the CQC or other statutory bodies for those properties where serious concerns over the environment have been raised. Staff morale is further affected by delays or poor developments, rather than being lifted by improvement and the successful execution of an ambitious strategy. Delays or mismanagement of large developments gives risk to new developments that are unfit for purpose, causes delays to moving to new, better environments, negative financial impact and has a further

### Gaps in Control

- Completion of a matrix of condition reporting on the condition, management and issues pertaining to all un-owned estate where we are tenants (expected completion with 60 days). The Director of Capital, Estates and Facilities has commissioned independent advice to provide the assurance around the estates and facilities adherence to statutory requirements (asbestos, legionella etc.) – regular reports awaited (first one in 45 days). More robust change management procedures - a more robust process is being implemented and will be applied by operations and estates and embedded through the CRG (within 45 days). Clinical team awareness and management of environmental risks with a designated responsible person applied in operations, with a specific estates focus (c 120 days).

### Gaps in Assurance

- Because of the nature of interdependencies with other risks, there should be a twice yearly formal discussion held between the chairs of the FPC, QC, AC to ensure the QC and AC chairs are appropriately sighted on issues at FPC, regarding estates.

### Action plan progress summary

- Internal audit reports of estate and property and capital processes commissioned by the Director of Capital, Estates and Facilities.
| Request for Closure | No |
**Principal Risk 11 (QI delivery):** There is a risk that the significant time, resource and money that the trust has invested in quality improvement will not result in the improvements in quality and efficiency of services that is anticipated.

<table>
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<tr>
<th>Owner</th>
<th>Initial</th>
<th>Current</th>
<th>Target</th>
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<table>
<thead>
<tr>
<th>Potential Causes (links to the CRR)</th>
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</thead>
<tbody>
<tr>
<td>QI devolves authority to teams to make changes to improve quality of care and relies on teams using data to make improvements through a structured methodology. Lack of clinical engagement. Demand for services reduces time available within clinical teams for QI. Cuts to services reduces resource available for QI. The iCare QI programme fails to deliver improvements in bed pressure.</td>
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</table>

**Key Controls**

Investment in a clear methodology, training rolled out, dedicated QI resource. QI team assist and monitor progress with each project. QI Programme Board monitors progress of QI delivery.

**Sources of Assurance**

Data is collected for each project from inception. The data plan is drawn up individually by project and projects are assigned a project progress score on a monthly basis. SMT members updated bi weekly. Bi monthly reporting to QSC and Board. Value for money assurances. Weekly iCare meetings.

**Assurance on the effectiveness of Controls**

New governance processes are beginning to demonstrate the effectiveness of controls for this programme. Weekly iCare meetings are in place and attendance includes senior leaders from across the Trust. It is anticipated the newly established Quality Centre and the CQC improvement Plan Delivery Board will also both support the programme’s direction.

**Request for Closure**

No

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No improvements made to quality or efficiency of services. Reputational risk to organisation as known externally to be pursuing QI agenda. Financial risk of negative return with no improvement in quality. Disengagement of workforce. Bed pressures remain a significantly challenging issue impacting on quality of care and performance ratings.

**Gaps in Control**

An effective balance between pursuing increased performance and implementing quality improvements has yet to be achieved. iCare QI programme in progress with 4 main work streams.

**Gaps in Assurance**

Not all the data is available within Business Intelligence for projects at the current time. Therefore a lot of data is collected manually currently.

**Action plan progress summary**

Actions to achieve an effective balance between pursuing increased performance and implementing quality improvements is on-going. It is envisaged CQC Improvement Plan Delivery Board discussion will further support this. Improvements to QI data are progressing through the development of the Trust dashboard ('Deming'). Data requirements for the iCare programme are now integrated into Deming’s development roadmap.
Potential Causes (links to the CRR)

There is a risk that due to the ongoing and severe financial pressures in the NHS, South London Health Economy and SEL STP contract values will be offered and set at levels that would put patient care at risk. Currently, the key CCGs for SLaM (Lambeth, Southwark and Croydon) are all funded in the lowest quartile in terms of spend per weighted population. The Trust has been required to make more than £70m worth of savings in the last 3 financial years and there is a requirement of £16.4m CIP in 2018/19 (4.1% of turnover). Whilst this is seen as achievable it is still a very high requirement over a prolonged time period which is not seen as sustainable. Additional risk will also stem from the variability of financial health across the key commissioning boroughs. The acuity of our patients and demand for services continues to be higher than expected which has driven up average length of stay (bed days) and as such the need for overspill beds which are in excess of budgets and disproportionately expensive. In addition, delayed transfers of care continue to be commonplace due to continued constraints in local government and particularly social care. The Trust has multiple and emergent requirements that need additional financial resource and divert management focus (e.g. Operational reorganisation, developing Alliances, CQC preparation). The Trust has significant challenges recruiting and retaining key staff groups (e.g. Band 6 community nurses) this will continue to ramp up the pressure to utilise agency staff despite a decrease in the Trust’s agency ceiling.

Key Controls

Regular Performance meetings (PACMAN) for all Operational Directorates and corporate areas where the financial position are monitored are held monthly and are escalated to a Portfolio board chaired by the CEO. The Trust has been able to step up and down these meetings as required allowing decisions to be made in an agile way. Financial performance (incl. CIP and QIPP) are reported routinely to the FPC, Trust Board, NHSI and SMT. Overspill beds have been managed via an escalation process to Gold and Silver command structures and as a result private bed usage has reduced although it remains a significant downside risk. Quality Impact Assessments are in place for all CIPs to ensure patient care and safety are assured. New Operational delivery units will allow better cost control once they are fully developed. The Trust has a fully staffed PMO that works closely with Finance and Operational teams.

Gaps in Control

QI, value based, programmes are established but still to be fully realised and measuring outcomes in terms of ROI will be a challenge. Delivery of the programmatic approach of PMO, QI Team and SlaM partners are underway. Sustainable processes and procedures for overspill beds and placements will be required to ensure long term delivery.
## Sources of Assurance

Outturn performance in line with monthly reports. Internal audit reviews of systems and processes. External audit review. Review meetings with commissioners. Year to date performance and forecasts are regularly monitored. Further recurrent and one-off opportunities being reviewed to mitigate risks. Mental Health Investment Standard has been agreed with commissioners for 2018/19 although how this will be spent remains subject to negotiation in some cases. QIPPs requiring specific cost reductions have been limited to circa £1.5m in 2018/19 (as opposed to circa £10m in 2017/18). In addition, none of these QIPPs are related to adult acute pathway bed reductions. Planning and Contracts for two-years finalised by 23rd December 2016. Where QIPPs are not being delivered by the CCGs the Trust is challenging and seeking recompense as appropriate. Reports are made to the Finance and Performance Committee and the Trust Board. Increased challenge reduced spend in 16/17 and 17/18. However, the challenge in 2018/19 is significant as the ceiling has reduced by more than £2m.

## Gaps in Assurance

An initial long term financial strategy driven by a financial model has been developed but needs further engagement and analysis to ensure inputs, processes and outputs are appropriate and owned by the wider organisation. Financial Modelling of new contractual models and impact of individual Borough approaches including partnership collaborative agreements need to be completed and assessed including Lambeth Living Well Network and Croydon Alliance.

## Assurance on the effectiveness of Controls

- Internal audit programme; Audit Committee review with FPC. Actual performance in line with forecasts.

## Action plan progress summary

- Core Finance Risks now on Datix - Actions will need cross reference to existing finance work plan spread sheet(s) to be manageable and copy to be attached to Datix entry.

## Request for Closure

- No
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<thead>
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### Owner: Initial Current Target Trend

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<td>Level</td>
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<tr>
<td>Last reviewed</td>
<td>Jun-18</td>
<td>Next review</td>
<td>Sep-18</td>
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### Potential Causes

An increasing list of training topics deemed as mandatory. Training requirements potentially over-specified for some groups of staff. Training capacity issues, both in terms of trainer and venue availability. Challenges with the new learning management system (LEAP). Slower development of e-learning alternatives than would be ideal. Wide variation in line manager’s oversight and direction of local staff attendance.

### Key Controls

Mandatory training policy. Mandatory and service specific training (inc. e-learning). All training is competency based and fully assessed. LEAP. Mandatory training compliance linked to individual appraisals. Report of Trust’s statutory and mandatory training to align our requirements with those of our SLP partners and reduce the burden of training.

### Sources of Assurance

Education & Training Committee. Monthly training dashboard. E&D training compliance reports. Mandatory training compliance part of routine Performance and Contract Management reports to Board, Audit Committee and Quality Committee.

### Assurance on the effectiveness of Controls

Actions and controls introduced over the last 12 months have produced a steady improvement in overall Trust-wide levels of mandatory training, from 76% in April 2017 to 86% in July 2018 just above the Trust’s target of 85%.

### Request for Closure

No

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### Potential Consequences

Difficulty in releasing staff for training, loss of faith in the data LEAP holds and lack of management oversight leading to poor mandatory training compliance rates. Lower mandatory training rates could lead to patient care and staff safety and well-being compromised an extreme cases the Trust could be liable for failing to meet its own and external standards including enforcement action.

### Gaps in Control

Inaccuracy with training data as ESR out of line with LEAP. Inherent weakness of manual workarounds whilst LEAP issues addressed. Management actions to address non compliance with key training (PSTS, BLS and ILS training) yet to embed. Statutory and mandatory training review report assessment and action plan.

### Gaps in Assurance

LEAP data accuracy concerns.

### Action plan progress summary

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COMMITTEE REPORT TO THE TRUST BOARD: PUBLIC
18 SEPTEMBER 2018

Title | FINANCE AND PERFORMANCE COMMITTEE (‘FPC’) UPDATE
---|---
Non-Executive Director | June Mulroy, FPC Chair

Purpose of the paper

From FPC meeting of 23 July 2018
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.

Board Assurance Framework

- **BAF Risk 2 Operational delivery structure** – If the Trust does not deliver services from an effective operational structure, have clear care pathways and clinically driven care protocols, there is a risk that there will be delays in care and that transfers between services will adversely impact the quality of care and service user experience.

- **BAF Risk 3 Informatics** – Failure to develop Trust informatics systems could adversely impact the quality of care, staff experience and our ability to meet contract requirements.

- **BAF Risk 8 Finance - contracts** – If new contract values and the transitions to new contracts do not provide sufficient financial resource to deliver high-quality clinical care, there is a risk that the Trust will not be able to provide timely access to safe high-quality services across all Boroughs and care pathways.

- **BAF Risk 9 Estates** - The Trust estate strategy will be delivered over the next five years and is dependent on significant capital investment. During the five years, services will continue to be delivered from buildings of differing age, quality and standards and there is a risk that the experience of staff and patients is adversely affected and that safety is compromised. Furthermore, there is a risk that developments will be unfit for purpose, delivery of major new buildings will be delayed or go over budget.

- **BAF Risk 12 Finance – cost management** - If services and departments do not deliver within their budgets, do not deliver the planned cost improvements, QIPPs and CQUINs and if we do not manage within Trust capacity the risk is that costs are uncontrolled and that the financial position of the Trust is destabilised which will prompt intervention by the Regulators.

KEY ISSUES SUMMARY

<table>
<thead>
<tr>
<th>Actions proposed to address key issues</th>
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<tr>
<td><strong>(1). Procurement Department: transformation options.</strong> The paper set out 5 options for how the Procurement function may be changed to move from an operational team to a strategic function with the intention of proactively managing all SLaM spend. Current discussions with SLaM’s SLP partners about</td>
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The CFO and Head of Procurement will present a decisions paper to the next FPC meeting, focused on options 2, 3 and 4 and reflecting responses from SLP partners, GSTT and NELFT to the ‘exam questions’ suggested in the FPC meeting (October 2018).
<table>
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<tr>
<th>KEY ISSUES SUMMARY</th>
<th>Actions proposed to address key issues</th>
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<tbody>
<tr>
<td>an SLP approach to procurement are moving only slowly and the FPC expressed concern at the implications for the pace of implementation of any SLP shared service procurement arrangement.</td>
<td>The FPC agreed that 2 options (revise the SLaM in-house team, and tender the procurement service) are unlikely to achieve the desired objective on an appropriate timescale.</td>
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<tr>
<td>The meeting discussed information (‘exam question’ type answers) that would help SLaM decide between the 3 remaining live options, being to pursue shared service arrangements with: (1) the SLP; (2) Guy’s and St Thomas’ NHSFT (‘GSTT’); or (3) North East London NHSFT (‘NELFT’). The latter 2 Trusts currently provide procurement hub arrangements to other Trusts, albeit that SLaM would be the first Mental Health Trust partner for GSTT.</td>
<td>The Director of CEF will revise the CEF Dashboard and the modernisation programme paper and will present these to the SMT and then to the next FPC meeting for ‘sign off’ (Oct.2018)</td>
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<td><strong>(2). CEF dashboard.</strong> The Director of Capital Planning, Estates and Facilities (‘CEF’) presented the agenda item, noting that:</td>
<td>(3). Intellectual Property (‘IP’) policy. The FPC discussed and approved the IP policy subject to amendment for points raised in the FPC meeting and</td>
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<tr>
<td>• the CEF Dashboard Report captures performance, tracks process improvement activities, and provides detailed updates on the programme and budget of the Douglas Bennet House and Children and Young Persons development as of month 2, 2018/19;</td>
<td>The Director of Strategy and Commercial will present a revised version of the IP policy to the FPC meeting (Dec.2018)</td>
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<tr>
<td>• the paper seeks feedback from the FPC on the content ahead of future submissions to the Trust Board. Comments received will be addressed and included for formal submission at the November 2018 Trust Board to align with the financial year quarters;</td>
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<tr>
<td>• key CEF developments include a Strategic Outline Case (‘SOC’) having been prepared for the Centre for Children and Young People’s Mental Health, and reviewed by SLaM’s Business Development and Investment Committee (‘BDIC’) earlier in the day. The FPC Chair advised that the BDIC had concluded that the SOC required further work.; and</td>
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<td>• to deliver at pace given current CEF resourcing, there is a tendency for CEF Department to rely excessively on design and build contractors to specify the necessary work. The FPC noted that such resourcing risks may affect the modernisation programme, as also may the fact that the Director of CEF is working with SLaM on only a 0.5wte basis. SLaM management needs to ensure that the Director of CEF can focus on strategic matters and avoid being drawn into day-to-day management (risk to flag to Board).</td>
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<tr>
<td>KEY ISSUES SUMMARY</td>
<td>Actions proposed to address key issues</td>
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<tr>
<td>subject to the policy being issued with a short review date such that in December 2018 the FPC can review a revised policy</td>
<td>The Head of Risk and Assurance will liaise with the Director of Human Resources to ensure that the Equalities and Workforce Committee discusses the risk of loss of key leadership team members and succession planning, and the BAF is updated to reflect those discussions accordingly (Sep. 2018)</td>
</tr>
<tr>
<td><strong>(4). Board Assurance Framework (‘BAF’).</strong> The FPC briefly discussed the BAF noting that the BAF appeared to omit the risk of loss of key members of the leadership team.</td>
<td>The COO will arrange for the admissions graphs (Performance Report 3.1.2) to be revised to use 'new demand' or 'discharges' as a more appropriate measure of service users coming into the system (Oct. 2018). The Outgoing Director of Performance, Contracts and Operational Assurance will circulate to FPC members, via the FPC Secretary, a dashboard showing length of stay trajectories month by month (July 2018).</td>
</tr>
<tr>
<td><strong>(5). Performance report, CIPs and QIPPs.</strong> The meeting discussed bed pressures, noting that as SLaM has a relatively low number of beds compared with Acute Trusts, performance is inherently prone to be more volatile. To help address this the Performance Report should use trajectory graphs rather than snapshot charts wherever possible (for example, for the ‘length of stay’ dashboard). It was agreed that bed pressures was a systems issue not an 'inpatient problem’. The FPC noted that admissions were broadly on plan and hence the main driver of increasing bed pressures must be length of stay. The Chief Executive’s view was that (given that admissions generally equate with discharges) a better measure of service users coming into the system would be new demand. The FPC noted that the admissions graphs for the 4 Clinical Commissioning Groups (‘CCGs’) allowed useful internal benchmarking comparisons. The FPC Chair noted that her recent visit to the Ladywell Unit evidenced that community services there were performing strongly. The FPC noted the importance of identifying behavioural drivers. For instance, staff at the Ladywell Unit were very clear that length of stay was key to achieving the 85% occupancy target. The FPC noted that commissioners have confirmed their commitment to maintain the bed base in 2018/19 and to plan to commission at 85% bed capacity utilisation.</td>
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<tr>
<td><strong>(6). Payroll outsourcing plans.</strong> The FPC noted that SLaM has decided to outsource its payroll service. Discussions are under way with the selected provider, NHS Shared Business Services (‘SBS’), a contract is in development for signature by the end of July 2018 and go-live is scheduled for 1 November 2018. SLaM is working through the possible implications for staff with the teams involved. SLaM has kept its SLP partners informed of its plans. The decision to outsource was prompted because despite considerable efforts we were unable to</td>
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</tbody>
</table>
**KEY ISSUES SUMMARY**

<table>
<thead>
<tr>
<th>Actions proposed to address key issues</th>
</tr>
</thead>
<tbody>
<tr>
<td>create a viable and sustainable shared payroll service with one of SLaM’s SLP partners. We want to put on the record our thanks for all the hard work by the payroll team over the years.</td>
</tr>
</tbody>
</table>

**Key points of assurance**

Points (3) to (6) above provide assurance

**Key risks to flag**

The FPC concluded that no matters required escalation for the attention of the Board (minutes 65.1). However the FPC considered that the Board should be made aware of certain key issues covered at the meeting namely:

- the CEF Department resourcing risk noted in item (2) above;
- the FPC’s approval of a new IP Policy (based on policies of GSTT and others) which will be tested against current contracts (item (3) above); and
- the FPC’s commendation for SLaM to continue to include a ‘policy on 1 page’ summary in its policies, as was done for the new IP Policy (item (3) above).

**Issues to be brought to the attention of Committees**

Equalities and Workforce Committee – see item (4)
The FPC will be taking over from the BDIC monitoring of NHS Alliance contracts.
The Audit Committee will receive a copy of this key issues report as a matter of course
Title  
BUSINESS DEVELOPMENT AND 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.

Please note that this report provides an update for the June and July BDIC meetings and the extraordinary BDIC held on 11 September.

Board Assurance Framework

Please indicate which of the Board Assurance Framework risks this report relates to, as applicable. The risks are set out below for you to delete as applicable.

Highlight any other risks arising and whether any issues require escalation.

BAF Risk 1 - Workforce - If the trust cannot attract, recruit and retain enough highly skilled staff, in the right settings with the ability to respond to organisational change the risk is that the quality of care may not be acceptable or consistent across services

BAF Risk 2 – Operational Delivery Structure - If the trust does not deliver services from an effective operational structure, have clear care pathways and clinically driven care protocols there is a risk that there will be delays in care and that transfers between services will adversely impact the quality of care and service user experience.

BAF Risk 5 – Partnership working with service users - If the Trust fail to listen to the experience of people that use services and / or fail to implement the learning from all sources of adverse incidents there is a risk that services will not learn, not improve safety and present unacceptable risks for people that use services.

BAF Risk 7 – Quality & statutory compliance - In the context of significant demand, change and unpredictable clinical situations there is a potential risk that the trust will fail to deliver the necessary regulatory actions (must do's) and quality improvements identified by the CQC or meet our other regulatory duties and therefore create a risk of breaching regulation and/or statutory duties.

BAF Risk 8 – Finance contracts - If new contract values and the transitions to new contracts do not provide sufficient financial resource to deliver high quality clinical care there is a risk that the trust will not be able to provide timely access to safe high quality services across all Boroughs and care pathways.

BAF Risk 9 – Estates - The trust estate strategy will be delivered over the next 5 years and is dependent on significant capital investment. During the five years services will continue to be delivered from buildings of differing age, quality and standards and there is a risk that the experience of staff and patients is adversely affected and that safety is compromised. Furthermore, there is a risk that developments will be unfit for purpose, delivery of major new buildings will be delayed or go over budget.

BAF Risk 11 – QI delivery - There is a risk that the significant time, resource and money that the trust has invested in quality improvement will not result in the improvements in quality and efficiency of services that
is anticipated.

BAF Risk 12 Finance – cost management - If services and departments do not deliver within their budgets, do not deliver the planned cost improvements, QIPPs and CQUINs and if we do not manage within Trust capacity the risk is that costs are uncontrolled and that the financial position of the Trust is destabilised which will prompt intervention by the Regulators.

BAF Risk 13 – Mandatory training - If the Trust fails to meets its mandatory training compliance targets as a result of poor local management oversight, data quality or availability of courses, there is a risk to staff and patient safety and of breaching regulation of the local training gaps with a risk to the safety of staff and patients.

### KEY ISSUES SUMMARY

<table>
<thead>
<tr>
<th></th>
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</tr>
</thead>
<tbody>
<tr>
<td>June BDIC</td>
<td>Update provided on Centre for Young Persons (CYP) and Douglas Bennett House Schemes</td>
</tr>
<tr>
<td>July BDIC</td>
<td>CYP SOC financial model and risks need further work</td>
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<tr>
<td></td>
<td>United Arab Emirates Update including Quality Improvement Advisory Contract Implementation Plan sign off</td>
</tr>
<tr>
<td></td>
<td>Maudsley Health Clinics financial performance</td>
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<tr>
<td></td>
<td>Centre for Translational Informatics Joint Estate Proposal between SLaM and Kings College London – seeking agreement in principle</td>
</tr>
</tbody>
</table>

### Key points of assurance

| June BDIC | Revised Terms of Reference approved |
| July BDIC | Update provided on Southwark |

### Extraordinary September BDIC

Matthew Patrick given delegated authority to progress development of Full Business Case for DBH and CYP schemes.

### Key risks to flag

| June BDIC | Deep dive on BAF risks in relation to estates discussed. BDIC noted the updates to gaps and assurances including formal, 6 monthly meetings between the chairs of Finance and Performance Committee, Quality Committee and Audit Committee. |
| Extraordinary September BDIC | Financial risks identified in CYP/DBH SOC but these will be addressed in full at FBC phase |

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

| July BDIC | Clinical Case for CYP SOC to be overseen by Quality Committee at Full Business Case stage. |
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.

This report covers a meeting of the Quality Committee which took place in June 2018, and subsequent Quality matters arising from the recent CQC inspection.

<table>
<thead>
<tr>
<th>KEY ISSUES SUMMARY</th>
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</tr>
</thead>
<tbody>
<tr>
<td>CQC warning notice and Our Improvement Plan</td>
<td>The agenda for the 11 September meeting of the Quality Committee has been prepared largely to provide the opportunity for the Committee to receive updates on work underway to affect quality improvements arising from the recent CQC inspection and warning notice. The Committee will move from bi-monthly to monthly meetings until at least April 2019. The Chair of the Quality Committee and other NED members are working with the Director of Nursing, Medical Director and Chief Operating Officer to ensure that the Quality Committee holds an appropriate place in the governance processes for all improvement work. Thought is being given with the Director of Nursing and the executive team as to what information should regularly come to the QC so it can carry out its assurance role for the Board fully without duplicating the executive team’s role in holding the organisation to account. The QC will also need to ensure it has the time to review amber as well as red scores for particular wards/teams.</td>
</tr>
<tr>
<td>Workplan</td>
<td>The workplan for the Quality Committee is being revisited in light of (a) ensuring floor-to-Board oversight; (b) more frequent meetings; (c) making sufficient space in meetings for robust discussion of key issues.</td>
</tr>
<tr>
<td>CAMHS: access to services</td>
<td>At its June meeting, the Quality Committee received a</td>
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</tbody>
</table>
presentation from CAMHS, which highlighted significant waiting times for services. The Committee has previously escalated these problems to the Board for increased visibility (20 February) and will continue to review the waiting time issues matter of urgency.

**Quality Priorities**
The Committee received data for the first quarter. Given that the Quality Priorities have been set over three years, the current status sets a baseline of performance rather than demonstrating trends. Work has been undertaken to align QI objectives with Quality Priorities. Both need to be aligned with our overarching strategic objectives.

**Beds and barriers to discharge: waiting times**
The Committee received an update on the MADE (Multi-Agency Discharge Events) held between South London partners to try to unblock the system. All high cost placements have also been reviewed. The committee asked for comprehensive information on waiting times across the Trust. This shows long waits in a number of areas (including non MHA inpatient beds) and variance between teams both in terms of what is measured and waiting times. The QC plans further work on waiting times.

**Board Assurance Framework: Quality Risks**
The Committee received a deep dive into the risks it has oversight of, namely:
- Risk 2: Operational Delivery Structure (shared)
- Risk 5: Partnership working with service users
- Risk 7: Quality and statutory compliance
- Risk 11: QI delivery.
The Committee will revisit BAF Risk 7 in light of the CQC inspection and warning notice.

**Safety Deep Dive**
The Committee looked at all “Must Dos” and “Should Dos” in the safety domain arising from previous CQC inspections. The Trust had more “Requires Improvement” in the safety than any other CQC line of inquiry. The committee has agreed the Trust’s approach to safety in the context of the requirements of health and safety legislation as well as the CQC’s findings.

**Medicines Management**
The Committee received an annual report, including an update on improving physical health checks post-rapid tranquillisation, which has also been identified as an issue by the CQC.

**Mandatory training compliance and requirements**
The Committee was offered assurance that compliance has improved but awaits the outcome of a review to streamline the demands on staff, as this has been ongoing for some time and is a priority.

**Inpatient and community QuESTTT**
Recognising that the Quality and Effectiveness Trigger Tool (QuESTT) is key apparatus by which the Committee and the Board has sight of ward performance, it had commissioned a report on compliance with its use and consistency of practice. The Committee was assured that compliance has improved but acknowledges that QuESTT is just one factor in the necessary triangulation of data to understand where hot spots may sit. The committee also noted the importance of the community team QuESTT which is currently being developed.
The Committee received an update on quality matters relating to the Alliance, using the 'red lines' tool. Whilst there is progress, there is more work to do on partnerships and the Committee is encouraged that updates are planned on a regular basis for the QC and the Board.

### Key points of assurance

#### Governance and oversight

The Quality Committee will meet monthly until at least April 2019. It is involved in discussions to ensure that it has an appropriate role as part of the Trust’s Improvement Plan, the right flow of information across the Trust and enough time to discuss key risks so it can carry out its assurance role for the Board fully.

**Board Assurance Framework: Quality risks**
The Board and Committee will revisit BAF Risk 7 in light of the CQC inspection and warning notice.

**Inpatient Quality and Effectiveness Trigger Tool (QuESTT)**
The Committee received assurance in respect of compliance and consistency of use of this tool, a key indicator in ward-to-Board governance and oversight.

### Key risks to flag

**CAMHS: access to services**
The committee will look further at the reasons for long waits in CAHMS and other services.

**BAF Risk 7: Quality and Statutory compliance**
The outcomes from the recent CQC inspection of services and Well Led inspection have an impact on the current ratings for BAF Risk 7 and must be reviewed as a matter of urgency.

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

**Statutory and mandatory training** – for the attention of the Equalities and Workforce Committee
The Committee awaits the outcome of a review to streamline the demands on staff, as this has been ongoing for some time and is a priority.
REPORT TO THE TRUST BOARD: PUBLIC
18 September 2018

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

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

Executive summary
The detail below refers to the Part II meeting held in July 2018.

<table>
<thead>
<tr>
<th>Ref</th>
<th>Item discussed</th>
<th>Summary of discussion</th>
<th>Lead Director</th>
<th>Reason for taking in PII</th>
</tr>
</thead>
<tbody>
<tr>
<td>BODPTII 24/18</td>
<td>Centre for Children and Young People</td>
<td>To consider the draft Strategic Outline Case.</td>
<td>Matthew Patrick</td>
<td>Commercial in confidence.</td>
</tr>
</tbody>
</table>
Board of Directors Meeting
To be held 30th October 2018
2:30pm - 5:00pm ORTUS, Maudsley Hospital

PROPOSED AGENDA: Part 1

Quality Improvement Focus
Presentation by teams about their QI Projects (located at the back of the room)

Opening Matters
/18 Welcome, apologies for absence & declarations of interest
/18 Minutes, Action log review
/18 Board Level Review of Serious Incident Beverley

Quality
/18 Risk Focus: BAF Risk – tbc
/18 Freedom to Speak up Guardian Zoe
/18 Quality Improvement Update Michael/Barbara

Performance
/18 Chief Executive’s Report Rachel
/18 Council of Governors Update Charlotte
/18 Finance Report & N2 NHSI Report Gus
/18 Performance Report Kris
/18 Capital Planning, Estates & Facilities Altaf (tbc)

Governance
/18 Freedom to Speak Up Guidance for Boards – Development of Improvement Action Plan Roger/Matthew
/18 Emergency Preparedness Policy Kris
/18 Briefing from the Equalities & Workforce Committee Sally
/18 Briefing from the FPC Meeting Steven
/18 Briefing from the BDIC Meeting Adam/Altaf
/18 Briefing from the Audit Committee Steven
/18 Briefing from the Mental Health Law Committee Kay/Geraldine
/18 Briefing from the Quality Committee Charlotte

For Noting
/18 Changing Lives Strategy – Final Altaf
/18 Report from previous month’s Part II Charlotte
/18 Wrap-up and Next Meeting

Please note that the minutes of 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.
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web site: www.slam.nhs.uk