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

Opening Matters
176/18 Welcome, apologies for absence & declarations of interest 2:30pm
177/18 Minutes, Action log review 2:30pm

Quality
178/18 Board Level Review of Serious Incident – Croydon & BDP Directorate 2:30pm
179/18 Risk Focus: Operational Delivery Principal BAF Risk – 2 2:30pm
180/18 Quality & Performance Report 2:30pm

Innovation
181/18 Research & Development Strategy 2:30pm

Value
182/18 Finance Report 2:30pm

Updates
183/18 Capital Estates & Facilities Dashboard 2:30pm
184/18 Chief Executive’s Report 2:30pm
185/18 Council of Governors Update 2:30pm
186/18 Mental Health Committee Update 2:30pm
187/18 Oversight & Steering Group Update 2:30pm
188/18 Board Development – Priorities & Deep Dive Programme 2:30pm

For Noting
189/18 Wrap-up & Next Meeting 2:30pm
190/18 Meeting Evaluation 2:30pm

The next Board of Directors Meeting will be held on 18th December 2018 2:30pm, at the ORTUS, Learning Centre, 82-96 Grove Lane, SE5 8SN. Maudsley Hospital
Quality Improvement Project: Improving the process of zoning in a community mental health team
Dr Alexander Adams, Dr Jennifer Perry, Dr Stephanie Young
South London and Maudsley NHS Trust.

Introduction
Zoning systems aim to ensure that service users receive appropriate levels of support by facilitating the delivery of targeted interventions. We identified this as an area for improvement as initial feedback indicated the meeting was repetitive, newcomers to the team didn’t understand why patients were in different zones and discussions were not being documented.

Measures
- Staff rated satisfaction, quality and efficiency out of 10 post meeting.
- % of patients handed over in SBAR style
- Duration of meetings
- % of patients in RED zone with documentation on ePIS
- Free text space in survey for qualitative comments

Results
% of Patients Handed over in SBARD format

Aims and Driver Diagram

Conclusions

Barriers to maintaining changes:
- Existing admin burden of care coordinators
- Reliance on one member of the team to promote the changes
- Differences in opinions about which changes were most helpful.
- Subjective measures of satisfaction

Next steps:
- Testing further change ideas
- Nominating a QI champion within the team to maintain changes
- Organising a Team Away Day to embed the collaborative nature of the project.
MINUTES OF THE HUNDRED AND TWENTY-SECOND MEETING OF THE BOARD OF DIRECTORS OF THE SOUTH LONDON AND MAUDSLEY NHS FOUNDATION TRUST
HELD ON 30 OCTOBER 2018

PRESENT
Roger Paffard Chair
Béatrice Butsana-Sita Non-Executive Director
Kristin Dominy Chief Operating Officer
Rachel Evans Director of Corporate Affairs
Professor Ian Everall Non-Executive Director
Mike Franklin Non-Executive Director
Duncan Hames Non-Executive Director
Gus Heafield Chief Financial Officer
Dr Michael Holland Medical Director
Altaf Kara Director of Strategy and Commercial
June Mulroy Non-Executive Director
Dr Matthew Patrick Chief Executive
Sally Storey Interim HR Director
Dr Geraldine Strathdee Non-Executive Director
Anna Walker Non-Executive Director

IN ATTENDANCE
Ermias Alemu Governor
Christine Andrews Governor
Jane Avis Governor, Croydon Council
Andy Bell Director of Finance
Marianne Caitane PPI Facilitator (CAMHS)
Jenny Cobley Lead Governor
Chithmini De Silva Freedom to Speak Up Coordinator
Jude Elli Lambeth KONP
Angela Flood Governor
Barbara Grey Director, QI and SLaM Partners
Sam Holmes FTSU Advocate
Charlotte Hudson Deputy Director of Corporate Affairs
Brian Lumsden Governor
Russell Mascarenhas NExT Director
Gillian Paul FTSU Advocate
Zoë Reed Director of Organisation and Community & Freedom to Speak Up Guardian
Gabrielle Richards Head of Inclusion, Recovery, Professional Head of Occupational Therapy and AHPs
Susan Scarsbrook Governor
Gill Sharpe Governor
Charlotte Spencer FTSU Advocate

APOLOGIES
Beverley Murphy Director of Nursing

BOD 154/18 WELCOME, APOLOGIES FOR ABSENCE, DECLARATIONS OF INTEREST (14.49)
Apologies were taken as above.

BOD 155/18 MINUTES, ACTION LOG REVIEW (14.49)
The minutes were approved as an accurate record of the September meeting.

**BOD 156/18 PATIENT / CARER STORY** (14.50)

The Board was joined by a presenter who wanted to share her experience as a carer for her daughter, who in turn is a carer for her.

A few years ago, her daughter had a mental health crisis and had to go to A&E. At 17, she was too old to go on to a children’s ward and too young to go on an adult ward. She was therefore kept in A&E on an assessment room, which has no bed. The presenter was worried that if she stayed with her daughter, she herself would suffer a health crisis and as a result had to leave her daughter in the care of a nurse all night. Both she and her daughter were already anxious and this made it worse. Fortunately, her daughter had the same nurse all night, was assessed in the morning and sent home the next day.

The presenter explained that the gap between CAMHS (Child and Adolescent Mental Health Services) and Adult Health Services is a problem, as is the lack of facilities for parents / carers to remain overnight with their children in mental health crisis. She added that something needs to be put in place when there are service users who care for one another; if she or her daughter are in hospital, there is no-one to look after the other should they find themselves in crisis.

The presenter felt that her daughter had received good care in CAMHS, and still does receive good service in adult services.

Geraldine Strathdee asked what kind of support the presenter would find helpful should she or her daughter be in crisis; the presenter felt that something should be put in place so that social services provide support when one of them is in hospital.

Anna Walker asked whether the presenter was aware of the Trust policy of involving carers / family members in the development of a service user’s care plan, which should pick up on important issues such as those she had raised. The presenter was not aware of that at the time. Anna Walker requested that awareness of this vital engagement is raised as the new Family and Carer’s Strategy is developed, so that staff routinely involve carers / family members in care plans as appropriate. Gabrielle Richards added that these issues had been raised at the Listening Event in October.

Matthew Patrick expressed concern that the presenter’s daughter had to wait 12 hours to be assessed in A&E and invited the Board to consider this in the context of the discussion at BOD15/18 on the agenda (Emergency Department pressures).

**BOD 157/18 CQC INSPECTION UPDATE & RISK FOCUS: BAF RISK 7** (15.00)

Michael Holland presented this item. The CQC’s inspection report is now in the public domain and the Trust has received a ‘Good’ rating overall.

The inspection found that there have been significant improvements in the forensic pathway, and older adults received an ‘outstanding’ rating in the ‘well led’ domain. However, the acute wards have been found to require improvement in the ‘safe’ and ‘effective’ domains and were rated inadequate in the ‘responsive’ and ‘well led’ domains.

As discussed at September’s Board, the CQC has issued the Trust with a warning notice under Regulation 29A (HSCA) in respect of the acute pathway and work has
been underway to design directorate-based improvement plans to address the issues raised in that warning notice, namely the operational effectiveness of systems and processes to ensure compliance with the Health and Social Care Act 2008 and significant variation in the quality of care between wards. The improvement work has been led by directorate-level senior management teams and has included work streams to design effective governance systems, set fundamental standards of care across services and identify key enablers (e.g. IT and data provision to monitor performance).

The improvement plans have been scrutinised through the Improvement Plan Delivery Board, the Trust Senior Management Team and the Quality Committee and have now been brought to the Board for approval ahead of submission to the CQC.

Béatrice Butsana-Sita noted the extensive plans submitted for each directorate and queried whether the key actions to deliver the improvements could be distilled to a dashboard of, say, ten metrics for the Board to consider on a regular basis. Matthew Patrick added that a measurement strategy is under development which will bring together the suite of metrics that will best indicate whether the ‘exam question’ set by the CQC warning notice is being answered.

Kristin Dominy added that a key factor in the successful delivery of the improvement plans is the work underway to improve flow in the system, which will be discussed at length at BOD158/18.

Anna Walker flagged a risk that the Board could be overwhelmed by the detail and urged them to concentrate on whether the Trust is meeting the fundamental regulations that it was found by the CQC to have breached. A measurement strategy is vital, as is clarity about the flow of information from floor to Board and vice versa. The same data should be considered throughout, but at different levels of granularity.

Anna Walker also asked that community services are not overlooked as improvements are put in place; the plans only address the inpatient wards subject to the warning notice, but community services are just as important. She requested that the development of a QuESTT (Quality and Effectiveness Trigger Tool) for the community teams is accelerated; Kristin Dominy explained that the Community QuESTT is being piloted and will be rolled out by 1 December, but that directorates are very aware of their most challenged teams, be they inpatient or community.

**Action:** Update the Board on the roll-out of the community Quality and Effectiveness Trigger Tool (QuESTT).

Gus Heafield added that, as executive sponsor of the workstream looking at governance, organograms have been developed showing the two-way flow of information from floor (inpatient and community teams) to Board and standardised structures for agendas, team meetings and escalation procedures have been introduced. They may be refined over time.

Anna Walker felt that the plans give her a strong sense of confidence but reflected that other Trust-wide improvement work – such as that around workforce equality – should be tracked alongside the CQC plans.

The Board approved the submission of the improvement plans to the CQC.

In light of the outcome of the CQC inspection, the Board considered amendments to BAF Risk 7 (Quality and Statutory Compliance), including an increase to the risk
rating from 12 to 16. The target risk rating is 6. Gaps in control, such as the need to blend the I-Care programme with work to improve flow so that they work consistently with one another, were recognised. Key controls include merging Performance and Quality meetings with the directorates, and standardising systems for reporting.

Geraldine Strathdee reported that the Oversight and Scrutiny Group with responsibility to oversee the Improvement Plan had now met twice and would bring a paper to the Board in December.

The Board approved updates to BAF Risk 7.

**BOD 158/18 EMERGENCY DEPARTMENT PRESSURE AND PATIENT FLOW (15.20)**

Matthew Patrick introduced this item, explaining that the Trust has been focussing on key drivers for variation in quality as demonstrated in the improvement plans approved by the Board. However, if demand and flow in the acute pathway are not addressed as a matter of urgency, the improvement plans will struggle to succeed; staff are under too much pressure and will be unable to deliver sustainable change. The approach of winter will only add to the pressure.

A plan has been developed to address flow but it does not come without a price tag that will put additional pressure on the Trust’s ability to meet its control total. Many of the proposed actions are cost-neutral, but many will cost money and reflect long-term underinvestment in mental health services. The Board was presented with two proposals to tackle flow – a “buy it all” option and the recommended “buy what we must, design what we can” option entitled *Optimum* - and approval was sought for additional spend this financial year to begin to address the challenges.

Kris Dominy pointed to the initiatives proposed, some of which relate to flow, some to interventions in Emergency Departments and some around the community offer. There are 23 initiatives on the flow improvement plan, some of which are already in place, the most significant of which include ring-fencing borough beds (to discourage expectations of an out-of-borough admission in the absence of an available bed); the ongoing community redesign; Multi-Agency Discharge Events (MADEs); the establishment of Red2Green processes across all wards; bringing in Social Care Discharge teams; setting up Crisis Cafés / peer networks and recruiting a junior doctor to each borough to support increased discharge activity. There are plans to introduce MADEs in specialist units.

Additionally, Home Treatment Teams (HTTs) will be enhanced to support Emergency Department assessment, and psychiatric liaison in EDs will be enhanced to give more resource for assessment. Fourteen beds will be procured through East London Foundation Trust to increase the number of ED assessment beds. Predictive care planning will provide a focussed and intensive winter care package around frequently admitted patients in order to give them additional support in the community to avoid crisis.

A new BAF Risk has been identified which relates to flow and capacity; the risk is currently rated at 20 with a target of 8. The Board was asked to approve the new risk: “BAF Risk 14 (Patient flow”) as articulated in the Board papers.

Duncan Hames supported the recommendation that the Trust commits the investment necessary to implement the *Optimum* option but noted that for there to be sustainable change, there will likely be cost pressures beyond the timescales
indicated. Kris Dominy explained that the interventions made this year to improve flow are expected to create savings that may mitigate cost pressures going forward, albeit that they are not currently quantified. Testing the success of each intervention this year will inform a redesign of processes to support sustainable and effective change.

Michael Holland added that there are processes at a clinical level which will certainly improve bed occupancy and length of stay, but what is not known is the potential impact of increased funding in the Home Treatment Teams. In respect of social care teams, long-term funding will partly depend on funding in local authorities, but there is evidence that where social care is embedded in the acute pathway, there are significant benefits. The South London Partnership’s complex care programme must also be taken into account as that will implement other pathways for crisis care.

Gus Heafield stressed that the recommended interventions have been driven by a commitment to quality, not cost. There are changes that need to be made immediately and some that need to be tested in order to ensure that they are sustainable and properly designed for the future.

June Mulroy supported the proposed plans but felt that the costs would be greater than currently estimated. She requested that the plan is revisited with a view to evaluating the impact on support services. She reflected that it can seem as though the Trust is filling a role of a place of sanctuary for people who have nowhere else to go, emphasising that housing associations and care communities need to be part of the conversation.

Roger Paffard noted that, if anything, the Board was demonstrating push back on whether the plan is sufficiently bold. He queried whether, if the North East London Foundation Trust model was followed, the Trust could continue with the same bed base if the community investment were greater.

Matthew Patrick summarised the four key signal KPIs the flow plan is designed to achieve, namely:

- No 12 hr breaches in Emergency Departments
- No s136 breaches
- No cancelled MHA assessments in the community
- No inpatients sleeping anywhere other than a bed

He queried the rationale for recommending the Optimum option as opposed to making immediate outlay to effect the urgent changes. Michael Holland reiterated that in order to build sustainable change, transformation is required to the processes in place, not the structure. It could be throwing good money after bad to just increase the bed base instead of focusing on delivery of care. That way, the Trust could find itself with the same problems, just across broader bed stock.

Anna Walker expressed strong support for the proposals. However, she offered a warning that improving performance in one area can often be to the detriment of another and urged the Trust to collect waiting time data to ensure that waiting lists are not negatively impacted by these changes. Michael Holland gave an assurance that flow is being scrutinised across community and inpatient services as a whole. The Trust is also hoping to get financial support from NHS Improvement to develop a data dashboard to measure system flow.
Mike Franklin supported the recommended proposals but expressed concern about plans to address patients with “challenging behaviour” on the basis that they can consume all the resources on an inpatient unit, preventing flow; he asked what this would mean in practice and whether there is a risk of patients being stigmatised with a label of “challenging behaviour”. Michael Holland explained that this refers to patients who are violent and can cause injuries on inpatient wards; a separate set of beds would create a safer environment. Geraldine Strathdee asked to see an evidence base for the interventions, for example based on NICE (National Institute for Health and Care excellence) guidance, such as the safe and effective use of medicines. Kris Dominy agreed that medicines optimisation is important and is one of the reasons that pharmacists have now been placed in community teams.

Gus Heafield re-emphasised that the Board’s decision on whether to approve the recommended spend will be a conscious decision about prioritising quality over the Trust’s financial performance, as the control total will not be met if this investment is approved with only partial funding by commissioners in 2018-19.

The Board unanimously approved the Optimum proposals, at an estimated cost of £1.49m in 2018-19 and £3.9m in 2019-20, with a caveat that this may still not be sufficient investment to effect the necessary change.

The Board approved the articulation and scoring of the new BAF Risk 13 (Patient Flow): “in the context of current capacity and increased demand, if there is a lack of integrated working by internal and external stakeholders, there is a risk of delays in patient discharge and optimum bed occupancy levels that may negatively affect patient outcomes and experience, staff morale and Trust finances”.

BOD 159/18 PERFORMANCE AND QUALITY REPORT (15.59)

Kris Dominy introduced the newly merged Performance and Quality report, which is in an interim format while a full re-design is underway, highlighting key points for the Board’s attention.

Action: Develop Performance and Quality Report content and format over November and December.

IAPT recovery rate performance continues to fluctuate and the IAPT pathway will be subject to a deep dive at Quality Committee in November. There have been improvements in compliance with statutory and mandatory training.

The Trust has now received from its commissioners their intentions for funding in the next financial year, which are being summarised and assessed so that the Trust can prepare its response. A date has not yet been set by which agreements must be made.

Geraldine Strathdee welcomed the combined quality and performance data and would welcome some new items such as headlines from NICE audits. Anna Walker requested sections on (a) caseloads in Home Treatment Teams and (b) preventing future deaths notices.

Mike Franklin found the report helpful but asked for context in relation to some of the data. For example, it is not clear whether the number of incidents of violence reported is acceptable or what the direction of travel is against target.
Duncan Hames found it hard to reconcile the data on delayed transfers of care (the Trust is performing better than the NHSE target) with the earlier discussion. If this information is considered in isolation or as a snapshot, it is misleading in terms of the current bed pressures.

**Action:** Length of Stay data to be added to Performance and Quality Report as a standing item.

He also noted the report that 254 children in Lewisham have been waiting over 12 months for face-to-face contact with services. Even allowing for the prospect that up to 80% of these relate to a data recording issue, that is still 50 children who are not receiving the care that they need. Kris Dominy explained that this statistic is part of the wider CAMHS story; the Trust is in constant dialogue with commissioners because ultimately the Trust just is not funded to be able to address this demand. Commissioners will sometimes provide funds to tackle a waiting list, but it is only as a one-off and not sustained investment. Matthew Patrick repeated the access target for CAMHS service provision, which is 35% of children and young people getting access to the services they need and is unacceptable.

The Board agreed that the Board should look at CAMHS waiting list / access data within the next two months with a view to escalating commissioning gaps as a matter of urgency.

**BOD 160/18 FREEDOM TO SPEAK UP GUARDIAN (16.11)**

Zoë Reed (Freedom to Speak Up Guardian) attended to present the bi-annual Freedom to Speak Up (FTSU) Guardian’s report to the Board, which describes how the FTSU function is being delivered within the organisation and the next steps that have been identified. The supporting paper was taken as read.

October is “Freedom to Speak Up Month” and Zoë Reed highlighted the activities that have been taking place, including the launch of new FTSU promotional material; FTSU Advocate attendance at Trust Values Days; FTSU presentations held at team meetings and training days across the Trust and attendance at national FTSU events. The FTSU advocates reached c.600 member of SLaM staff during the month, which has resulted in 24 expressions of interest from staff interested in becoming a FTSU Advocate.

22 cases have been reported to the National Guardian’s Office in the last nine months. Of these, nine had an element of patient safety / quality; 17 related to behaviours (including bullying and harassment) and nine cases indicated that the person was suffering detriment for speaking up to their line manager about an issue of concern to them. Themes identified by the FTSU service in Q1 and Q2 include (but are not limited to) staff speaking up but not being heard; bullying and harassment from management (with a poor union response); a sense that staff are not treated even-handedly within disciplinary processes; Reflect and Review checklists not being properly implemented; experience of perceived racism and the recent borough reconfiguration not being undertaken in a way that respects staff.

Zoë Reed emphasised that the sample is small, and it is for the Board to think whether the themes are symptomatic of wider issues. However, it is the FTSUG recommendation that these themes could be more widely explored e.g. via a staff survey. Anna Walker found it significant that the majority of cases relate to staff experience.
Mike Franklin admitted that he had at first been sceptical about the creation of the FTSU service as it could be seen to undermine the validity of existing policies and processes e.g. the grievance process, but he can now see how they can co-exist. He expressed concern about the apparent vacuum in terms of union support for staff and queried how the TU side can be better engaged. Sally Storey reported a significant increase in TU activity across the Trust over recent months, and the new staff side Chair is working with regional officers to increase the number of representatives.

Sally Storey expressed disappointment that issues regarding the borough reorganisation had been raised with FTSU. Learning from previous restructures had been applied to this consultation and process, plus no staff were at risk from redundancy and almost everyone secured their first choice of role. Directorate management worked very hard to work with anyone affected. Matthew Patrick added that he had personally looked at every single case where a member of staff was being moved as a result of the restructure and there was a real effort to manage the process properly. However, if in even one case the process could have been better, there was still learning to take from it.

Michael Holland reflected that University College London uses digital means to encourage people to speak up e.g. chatbots, which provide a mechanism to report bullying and harassment without fear of detriment. Zoe Reed was concerned that this would encourage more people to make anonymous submissions, whereas the ethos of FTSU is to encourage a more open culture of reporting.

Russell Mascarenhas asked how the effectiveness of FTSU initiatives are measured and whether performance is triangulated with other data e.g. the staff survey. Zoe Reed pointed to one of the recommendations in the report, namely to develop systematic triangulation of data from other relevant systems across the Trust.

Mike Franklin was appointed as the Non-Executive Director Lead for FTSU, as required by the new Board guidance.

**BOD 161/18 FREEDOM TO SPEAK UP GUIDANCE FOR BOARDS** (16.25)

Matthew Patrick presented this item, explaining that NHS Improvement and the National Guardian’s Office have issued guidance for Boards on Freedom to Speak Up (FTSU) in NHS Trusts. The guidance document sets out expectations of Boards in relation to FTSU and asserts that meeting the expectations set out in the guide will help a Board to create a culture responsive to feedback and focused on learning and continual improvement. Having a healthy speaking up culture is an indicator of a well-led Trust.

As the Executive and Non-Executive FTSU Leads for the Trust, he and Roger Paffard meet regular with Zoë Reed (Freedom to Speak Up Guardian) and individual advocates and have undertaken an initial review against the guidance with their help.

The review, with recommendations, was presented to the Board for endorsement. The Board agreed with the recommendations, including a Board deep dive in May 2019 and a repeat of the self-evaluation.

**BOD 162/18 QUALITY IMPROVEMENT UPDATE** (16.30)

Barbara Grey attended to present an update on the Trust’s Quality Improvement (QI) programme.
The Board was shown a diagram which demonstrated how the I-Care programme integrates with the CQC Improvement Plan workstreams, ensuring that key Trust initiatives support and complement one another.

One of the tensions in the improvement work is ensuring bottom-up co-production whilst working at pace. It would be counter-productive to overwhelm teams with too many improvements at one time.

In view of the findings of the QI foundation programme and the CQC report, the QI Team recommend that, in conjunction with King’s Implementation Science (KIS), a revised strategy for continuing to build the capacity and capability in the Trust is developed and presented to the Board in December 2018 (n.b. this was later revised to January 2018 as the December agenda had been finalised). It was noted that the strategy should also be presented to Quality Committee, which has oversight of the QI BAF Risk.

Béatrice Butsana-Sita asked how many QI projects are underway in the Trust, whether there is sufficient visibility of the successes and how many projects can be rolled out more widely. Barbara Grey pointed to the new tool on the intranet whereby QI projects can be registered, and outcomes viewed by all Trust staff. In addition to Trust-wide projects (e.g. I-Care), there are just under 100 projects underway. There has not always been visibility of the projects but the SLP conference was used to encourage staff to share their successes. 4 Steps to Safety is an example of an initiative that has been scaled up.

Matthew Patrick urged the clear articulation of when a scaled-up project becomes business as usual, or Trust policy. Anna Walker requested that the next strategy paper has clearly defined anticipated outcomes set out.

It was noted that QI projects are 60% more likely to succeed if they are co-produced with service users, who should also be involved in designing, delivering and evaluating projects.

**BOD 163/18 FINANCE REPORT AND Q2 NHSI REPORT** (16.53)

Gus Heafield presented the finance report, with the headline that the Trust is in the right place but only because non-recurrent spend has been applied for the whole year. There are significant ongoing and emerging financial risks that need to be mitigated.

In the latest return to NHS Improvement, the Trust has explicitly included the shortfall against the national pay award as an additional deficit and is not going to look for mitigations elsewhere to offset that shortage. The only way this deficit can be addressed is if further funding is received.

The major risks, including bed pressures, the funding required to address quality issues as discussed at BOD157 and BOD158 above, and issues outside of the Trust’s control such as the pay award, have all been brought to the Board’s attention. Current forecasts indicate that the Trust will be c.£6m adrift of the control total by the end of the year, not including the spend agreed at BOD158 to address flow.

It is therefore key to refine that forecast between now and the end of Q3 when the next return is due to NHSI. There is a risk that if the Trust does not meet the control total it will lose sustainability and CIP funding which will impact the capital funding programme. A revision of the forecast signalling that the Trust won’t meet its Control
Total would also risk intervention by NHSI. The finance team is therefore going through a rigorous scrutiny and challenge process, keeping NHSI up-to-date throughout.

Geraldine Strathdee pointed to recent benchmarking data which shows that SLaM is in the lowest quartile per capita for mental health funding and asked whether the funding gap can be articulated so as to demonstrate the lack of parity and challenges in delivery quality care. Gus Heafield agreed that this data will be important during contract negotiations with the CCGs.

Duncan Hames was not surprised by the figures presented, having been warned for some time that achieving the control total looked increasingly unlikely. Audit Committee was informed last month that the shortfall was likely to be £5-6m. He asked when the forecast would be formalised with the regulator. Gus Heafield explained that the there is a formal process, and the forecast outturn can only be amended at the end of Q2 and Q3. Therefore, a formal submission will be made to NHSI in mid-January albeit that they have been informed throughout that the position is growing more challenging. The Trust is of course still trying to mitigate the shortfall and will have to see what the results of those efforts are by January. The Board will be kept up-to-date and will approve the submission to NHSI.

Roger Paffard, on behalf of the Board, noted it on record that whilst formal changes to the forecast will be subject to the full assessment of all potential mitigations and further discussions with NHS Improvement the Trust is unlikely to meet its control total for 2018-19.

**BOD 164/18 CHIEF EXECUTIVE’S REPORT (17.10)**

Despite the majority of this meeting focusing on current challenges, Matthew Patrick wanted to use this opportunity to thank everyone in the organisation for achieving an overall rating of ‘Good’ in the recent CQC inspection. It is of particular note that every service inspected received a ‘Good’ or ‘Outstanding’ in the ‘Caring’ domain. It is clear that there is one pathway which is struggling, and support is in place to address that.

Further to earlier discussions about Trust finances, he pointed to new and creative ideas for delivering efficiencies, such as those put in place by the South London Partnership with the new models of care in forensics and Tier 4 Child and Adolescent Mental Health Services (CAMHS). These initiatives have been able to deliver efficiencies with real financial benefits and similar principles could be applied to the acute care pathway.

Matthew Patrick recorded his thanks to Amanda Pithouse, SLaM Deputy Director of Nursing, who has taken a role as Director of Nursing at Barnet, Enfield and Haringey Mental Health Trust; and Professor Anthony David, Vice Dean for Academic Psychiatry at the Institute of Psychiatry, Psychology & Neuroscience (IoPPN), who has moved to University College London to head up their Institute of Mental Health.

**BOD 165/18 COUNCIL OF GOVERNORS’ UPDATE (16.51)**

Jenny Cobley, Lead Governor, congratulated the Trust for maintaining its ‘Good’ rating in the recent CQC inspection, and hoped that the improvement plans in place to address variation in quality in the acute pathway are progressing well. She echoed Anna Walker’s earlier request for visibility on waiting times across the Trust.
Governors have concerns about floor-to-Board communication, and she has heard about staff not getting support from their managers or being informed (or consulted on) changes within the Trust. She noted the plans to make emergency beds available and hoped that staff have been informed of these.

Governor elections are underway to fill seven vacancies; unfortunately, there will still be a vacancy in the staff constituency as only one staff member stood for election and there were two vacancies.

Jenny Cobley welcomed government plans to invest more money in mental health services and hoped that SLaM would receive some of it.

BOD 166/18 EQUALITIES AND WORKFORCE COMMITTEE UPDATE (17.15)

The Board noted this update.

BOD 167/18 BUSINESS DEVELOPMENT AND INVESTMENT COMMITTEE UPDATE (17.15)

The Board noted this update.

BOD 168/18 FINANCE AND PERFORMANCE COMMITTEE UPDATE (17.15)

The Board noted this update in the context of earlier conversations regarding the Trust’s financial position.

BOD 169/18 AUDIT COMMITTEE UPDATE (17.15)

The Board noted this update.

BOD 170/18 QUALITY COMMITTEE UPDATE (17.16)

Anna Walker flagged two issues: first, a plea for clarity on what the Trust expects as “fundamental standards of care”, and second, the recognition that different teams face different issues in terms of making sustainable improvements and therefore there has to be granularity about what those issues are.

BOD 171/18 CHANGING LIVES STRATEGY – COMMUNICATIONS MATERIAL (17.18)

The Board noted the publication of materials to support the Changing Lives Strategy.

BOD 172/18 SOUTH LONDON MENTAL HEALTH AND COMMUNITY PARTNERSHIP BOARD MINUTES (17.18)

The Board noted this item.

BOD 173/18 REPORT FROM PREVIOUS MONTH’S PART II (17.18)

The Board noted this item.

BOD 174/18 WRAP UP AND NEXT MEETING (17.18)

Roger Paffard thanked the Board for an effective meeting. The next meeting is on 27 November 2018.

BOD 175/18 MEETING EVALUATION (17.19)
Altaf Kara led the evaluation on what he believed to be a productive and important meeting, with critical decisions having been made in relation to the flow plan and the related impact on the Trust’s financial position. He felt that these decisions would achieve outcomes which will be beneficial to the Trust’s communities. The meeting had focused on prioritisation, levers and metrics for significant improvement. On balance, it seemed right that approximately 70% of the meeting had been spent discussing quality improvement and workforce. He felt that financial data had been used insightfully.

Although the meeting had overrun, it was necessary for the purposes of holding a robust discussion.

The meeting ended at 17.22.

The date of the next meeting will be:
27 November 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)
### Public Board meeting 27 November 2018 – Action points

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<tr>
<th>Ref</th>
<th>Issue/Board Paper</th>
<th>Action</th>
<th>By</th>
<th>When</th>
<th>Status</th>
<th>RAG</th>
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<tr>
<td>BOD 139/18</td>
<td>CQC Inspection Update and Risk Focus</td>
<td>Schedule stocktake on Our Improvement Plan for December 2018</td>
<td>RE</td>
<td>Dec 18</td>
<td>Scheduled for December 18</td>
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<tr>
<td>BOD 139/18</td>
<td>CQC Inspection Update and Risk Focus</td>
<td>Schedule deep dive into BAF Risks 2 (Operational Delivery Structure) and 7 (Quality and Statutory Compliance) within the next two months.</td>
<td>RE</td>
<td>Oct 18 – Nov 18</td>
<td>BAF Risk 7 was taken in October; BAF Risk 2 is on the November agenda.</td>
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<tr>
<td>BOD 147/18</td>
<td>Board Assurance Framework review</td>
<td>Guidance on scrutinising and reporting BAF risks to be prepared for Board sub-committees with oversight function</td>
<td>BM, RE</td>
<td>Dec 18 / Jan 19</td>
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<tr>
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<td>CQC Inspection Update &amp; Risk Focus: BAF Risk 7</td>
<td>Update the Board on the roll-out of the community Quality and Effectiveness Trigger Tool (QuESTT).</td>
<td>BM</td>
<td>Nov 18</td>
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<tr>
<td>BOD 159/18</td>
<td>Performance and Quality Report</td>
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<td>KD</td>
<td>Nov 18 - Dec 18</td>
<td></td>
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<td>BOD 159/18</td>
<td>Performance and Quality Report</td>
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**Key:**
- Green – completed
- Amber – on schedule
- Red – not on schedule
REPORT TO THE TRUST BOARD: PUBLIC
27 November 2018

<table>
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<tr>
<th>Title</th>
<th>Board Level review of serious incident – Death of a patient on Gresham 1 Ward, Croydon and BDP Directorate</th>
</tr>
</thead>
<tbody>
<tr>
<td>Author</td>
<td>Rachel Souster – General Manager, Inpatient and Crisis, Croydon</td>
</tr>
<tr>
<td>Accountable Director</td>
<td>Dr Hugh Jones, Clinical Director, Croydon and BDP Directorate</td>
</tr>
</tbody>
</table>

**Purpose of the paper**
This paper is being presented to the Board as part of the changes to improve Board oversight of Serious Incidents. The Trust has a statutory obligation to review serious untoward incidents (SUI) identify root causes, and identify lessons learned to prevent further occurrence. The aim of the Board review is to ensure the Board are satisfied the incident has been thoroughly investigated and to have assurance regarding delivery of the recommendations.

The Board require oversight and assurance that recommendations from the SUI are being implemented to reduce potential future harm and to ensure that Lessons Learned are disseminated with the Acute Care CAG and ensure where appropriate there has been Trust wide Learning.

**Executive Summary:**
Ms X, was a 21 year old female admitted to Gresham 1 ward, who died on 11 February 2017 following an act of serious self-harm where she cut her neck with a razor blade that had been secreted on her person.

A comprehensive investigation was completed. The investigation team found that the staff had made all reasonable attempts to prevent Ms X self-harming. No one root cause was identified although the team highlighted the challenges of managing repeated self-harm on inpatient units. One factor was identified as possibly contributing to the outcome which was that the cumulative effect of self-harm may have increased the risk of an adverse outcome.

The coroner’s inquest returned a narrative verdict and the corner identified a gap between an advanced (pat down) search and an intimate search. A PFD report was sent to the Department of Health as the coroner felt this was a national issue.

One recommendation was made by the comprehensive investigation on which work has already commenced. A review of the Search Policy is also underway.

**Risks / issues for escalation**

**BAF Risk 5** – Partnership working with service users.

**BAF Risk 7** – Quality & statutory.

**BAF Risk 13** – Mandatory training

**Additional issues for note/escalation**
The inquest for Miss X identified additional learning for the Trust with a Preventing Future Death notice sent to the Department of Health. This learning related to the process for searching patients.
on inpatient wards to ensure that staff are confident in thoroughly checking patients for risk items to ensure their safety while maintaining their privacy and dignity. Immediate updates have been made to the Trust’s search training with a revised search policy currently in development.

Committees where this item has been considered

<table>
<thead>
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<th>Date</th>
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</thead>
<tbody>
<tr>
<td>12/04/2018</td>
<td>Trust Serious Incident Review Group</td>
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1. Introduction

On the 10 of February 2017 Ms X self-harmed using a razor blade whilst an inpatient on Gresham 1, she was transferred to Kings College Hospital A&E but subsequently died. The paper is being presented to the board to provide information on Recommendations and Lessons Learned, and to ask the board to ensure they are satisfied with the action plan and the oversight of the plan within the Croydon Directorate with the oversight of the Trust Serious Incident Review

2. Background

Ms X was a young woman with a complex diagnosis of emotionally unstable personality disorder, a history of eating disorders, depression and of suicidal acts and self-harm. In her teens, Ms X underwent a series of CAMHS inpatient admissions in SLaM, and across the country. The longest of these was at Woodland House in Kent which lasted from July 2013 until March 2014 when she was transferred, as an adult, to Gresham 1 in February 2015. Ms X was discharged from the ward; however in September 2016 she had a further admission, again to Gresham 1 ward.

In the community, Ms X had several episodes where she tried to engage with Touchstone, the Croydon Personality Disorder Service, but she found the treatment and group work very challenging. Ms X had a care coordinator from the Treatment Team who coordinated and provided medical reviews when required and liaised with the other agencies. During this time, she lived at home with her father and his partner. Her father was her main carer and very involved in her care.

Although Ms X had on-going input from a number of clinical teams Ms X continued to experience high levels of anxiety and distress. The consultant psychiatrist from the personality disorder service formulated that Ms X self-harmed “in order to try to cope with her unmanageable feelings.”

Towards the end of 2016 Ms X was engaging with Touchstone to a limited degree. However she struggled to manage distressing thoughts and became largely mute and unresponsive, using only gestures to communicate. Nevertheless she attended groups as well as sessions with her psychotherapist. In December 2017, Ms X’s risks were reported to have escalated and Touchstone worked with the Croydon Treatment team to monitor and contain her level of self-harming and suicidality. A medical review was arranged and anti-depressant medication commenced.

On 6 January 2017 Ms X took an overdose of prescribed medication. Her community teams were informed that she had been admitted to hospital by her father. Ms X remained in Croydon University Hospital for three days before she was deemed medically fit to be transferred to Gresham 1 Ward where she was admitted as an informal patient.

Initially Ms X managed well on the ward as an informal patient but towards the end of January her distress increased and her self-harming behaviour escalated. She was placed under a section of the mental health act and her observations levels were increased to 1:1 and then 2:1 observations at arm’s length to maintain her safety. On every shift the ward team carried out searches of both Ms X
and her room visually and with the aid of a metal detector. Ms X’s father was consulted and actively involved in this risk management plan providing information on where Ms X hid items at home and assisting in searches when visiting Ms X. The ward team also consulted her mother.

On the 8 February Ms X cut her neck with a razor blade, which she had hidden, and required admission to Kings College Hospital for treatment. She returned to the ward on the 9 February.

During the day on 10 February Ms X spoke with staff and expressed suicidal ideation. She also handed in a piece of razor blade to staff that she had concealed. Her father visited that evening and was allowed to stay later than usual to support Ms X with her thoughts and feelings.

3. Description of Incident

During the latter part of the evening Ms X became distressed and was supported by her observing nurses. She requested for a drink and was escorted from her bed area to the dining room. She then stood with the observing nurses, looking at the staff photo board by the ward entrance. Suddenly she quickly ran from the nurses, through the day area and down the bedroom corridor. The observing nurses ran after her but she was observed by another staff member (who was in the corridor completing 1:1 observations with another patient) to cut her neck at which point she started bleeding heavily.

The staff present immediately attempted to stop the bleeding and medical support and an ambulance were called. Both Bethlem Hospital duty doctors attended and provided medical treatment until the ambulance arrived.

Ms X was transferred to Kings College Hospital A&E but sadly died at 02:54am on 11 February. The medical evidence at the inquest demonstrated that this injury had damaged a blood vessel.

4. Duty of Candour, Being Open and Staff Support

Based on the information available to the review the investigation found that the Duty of Candour was met by the clinical team and partially met by the investigation at this time.

The investigators found that there was frequent contact with Ms X’s parents during her episode of care. When the incident occurred both the consultant psychiatrist from the ward and from the specialist personality disorder service contacted Ms X’s parents, offered them support and an opportunity to meet with them. The Consultant, Head of Pathway and staff met with Ms X’s father at his request on Monday 13 February. Ongoing support was provided by the CMHT.

A letter of condolence was also sent to Ms X’s father by the deputy director who offered to meet with members of the family to discuss any support they might require at such a difficult time.

The investigators contacted both of Ms X’s parents to offer a meeting to discuss the Terms of Reference for the investigation and any concerns they may have had about Ms X’s care. Her father did not respond but her mother was keen to meet with the investigators. Several dates were offered for the meeting, Ms X’s mother found the earlier dates problematic, due to her personal circumstances, and so the meeting took place on 1 September 2017.

The ward team were supported on the day by the on-call manager, ward consultant and on call consultant.

The Head of Pathway attended the ward immediately on the following working day and provided support to the team.
A CISS debrief was also requested and held on the ward.

5. Summary of findings

- Ms X was undoubtedly had a high, long term risk of self-harm that could, by accident or intent, lead to her death. The staff interviewed in this review described her as a very pleasant young woman who they tried hard to engage with and keep safe.
- The investigators found that the three clinical teams involved in her care worked partnership with Ms X and her family, principally her father. They demonstrated persistence and a clear commitment to the potential benefits Ms X could draw from treatment where it was possible for her to engage. The teams showed compassion for the distress she experienced which led to her to self-harm.
- Given Ms X’s recent history it was sadly predictable that Ms X would make another attempt to harm herself and she confirmed as much to the doctor who saw her when she returned from being treated at Kings.
- The ward team tried all reasonable methods to locate razor blades, or their fragments, that Ms X was suspected to have hidden on her person, in her belongings or in the environment. She was also placed on 2:1 observations in an attempt to prevent her from harming herself or to ameliorate the consequences. The damage that Ms X caused to her legs and neck by making frequent, deep cuts considerably increased the likelihood of an adverse outcome.

6. Notable practice:

- The ward team tried to engage support with managing the risks from experts in the Croydon Personality Disorder Service and also Ms X’s parents
- During interviews the majority of the staff demonstrated a particular warmth towards Ms X.

7. Contributory Factors and root causes

No root causes were identified. The reviewers concluded that the ward team tried all reasonable methods to locate razor blades or the fragments of them that Ms X was suspected to have hidden on her person, in her belongings or in the environment.

1 contributory factor was identified:

While ward staff tried hard to manage incidents and prevent recurrences of self-harming behaviour the cumulative effect the damage that Ms X was inflicting to her legs and neck by frequent deep cuts considerably increased the risk of a severe outcome.

8. Lessons Learned and Recommendations

The Trust’s internal investigation made one recommendation:

Specialist training should be offered to staff who work on all inpatient units that are managing patients with persistent self-harming behaviour.

A further recommendation was made following the coroner’s inquest to review the Trust Search Policy as the coroner felt it was ambiguous and unclear. The corner highlighted that there was a gap between a pat down search and an intimate search - this is defined in the policy as a body orifice search. It was felt that the interpretation of the policy meant that staff did not feel able to ask Ms X to remove clothing (including her bra) which may have assisted in finding secreted items.
9. Action taken so far:

The Education and Training department have reviewed and update their Management of Self Harm and Suicide Training in order to include the learning from this incident, as well as other incidents involving self-harm.

The Head of Nursing for the Acute Care CAG is working with a Clinical Psychologist to develop further specialist skills training for inpatient staff in managing repeated self-harming behaviour.

A Blue Light Bulletin was sent out to all staff to clarify the search policy following the inquest. Immediate updates to training have been completed by the Trust lead, which are being incorporated into the review of the Trust search policy, originally due for completion in September 2018 but this has since been delayed.

10. Oversight and Assurance of Implementation of recommendations

The Trust’s Director of Nursing will maintain oversight of the actions through the Trust Serious Incident Review Group and Action Plan Assurance meetings.
Purpose of the paper

This paper presents a review of the operational delivery BAF Risk 2 as part of the Board’s commitment to looking in-depth at one of the risks on the Board Assurance Framework at each Board meeting.

This paper:
(a) reflects recent SMT discussions to bring the risk up-to-date particularly in light of the CQC inspection report;
(b) allows the Board to assess and confirm the current risk rating;
(c) considers the current controls and assurances in place and whether they are being reviewed at the right level;
(d) identifies any gaps in controls and assurance and whether appropriate action plans are in place and progressing.

Executive summary

BAF Risk 2 focuses on the risks to quality associated with our current models of organisation and delivery.

The Board received a risk focus report for this risk in April 2018 that highlighted two main mitigations with different implementation time lines: the Borough Reorganisation targeted for completion in June 2018 and the iCare programme designed on a rolling QI basis to run over a 9-12 month period.

Since then, the Borough restructure has been completed (June 2018), the iCare programme has progressed and the CQC have issued a Regulation 29A (HSCA) warning notice for the Acute and PICU pathway and published its report arising from the recent inspection of the Trust.

BAF Risk 2 has been reviewed to take account of the changes and new challenges.

It is proposed that the level of risk is retained at 16 and revised to reflect the current status and read-across to other risks on the Board Assurance Framework.

The existing BAF Risk 2 is at Annex A and the proposed revised BAF risk at Annex B.

Risks / issues for escalation

This report covers BAF Risk 2 (operational delivery):

Committees where this item has been considered

<table>
<thead>
<tr>
<th>Date</th>
<th>Committee / Meeting</th>
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<tbody>
<tr>
<td>12/11/18</td>
<td>Trust Senior Management Team</td>
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1. Introduction
The aim of this risk focus report is to provide the Board with an opportunity to:
   a) Confirm the BAF risk is accurate and up to date;
   b) Be confident that the listed controls and assurances are in place, sufficient and being reviewed / monitored at the right level;
   c) Focus on the gaps in controls and assurance and be confident appropriate action plans are in place and progressing.

2. Risk description
It is proposed that the risk description should be slightly amended to explicitly reference the criticality of the operational structure providing good leadership and governance.

3. Ownership
The risk is currently owned by the Chief Operating Officer supported by the Medical Director and Director of Nursing, with oversight maintained by both the Quality Committee and Finance and Performance Committee. As the mitigation of this risk continues to involve both operational structure and quality controls and assurances, it is proposed that this ownership continues.

4. Risk rating rationale
The borough restructure was completed in June 2018 and was welcomed by commissioning partners as it now more clearly aligns to their areas of responsibility and interest. However, the restructure and supporting governance processes are not yet fully embedded to deliver consistent quality leadership, clinical oversight and supervision. In particular, CQC noted examples of governance systems not identifying unacceptable practice, leadership quality variations and inconsistent communication and information sharing with staff in some wards/teams.

The iCare programme was designed as a longer-term programme on a rolling QI basis, and is in the early stages with evidenced-based outcomes yet to be identified and delivered. New clinical initiatives, R2G and Inpatient Care process models, are also in early stage of roll out and need embedding. The CQC report noted excessive unwarranted variation in delivery of care, excessive complexity in community provision and issues with flow of patients into and out of the acute care pathway and delayed patient discharges.

A number of mitigation measures have been implemented, most notably the CQC improvement plans for governance, leadership and culture, patient flow and fundamental standards of care.

However, until these plans are fully implemented and embedded the likelihood of this risk being realised remains at 4 (likely) and considering the established consequence descriptors relevant to this risk (as shown Annex C), the potential consequence remains at 4.

Therefore, the risk score is proposed to remain at 16 (4×4).

5. Risk appetite
The risk encompasses elements of operational performance, quality, finance and reputational risk. The current risk appetite has been set as cautious to open, reflecting that a degree of finance risk has had to be accepted to reduce reputational and quality risks, and is considered to remain appropriate.

6. Risk target
The risk target is currently set at 6, based on a likelihood target of 3 and a consequence target of 2.

The likelihood target of 3 (possible might happen or recur occasionally/monthly) is considered to be realistic and achievable.

However, considering the established consequence descriptors relevant to this risk (as shown in the Annex C), it is considered that the current target of 2 is highly ambitious and potentially unrealistic and unachievable, for a complex, large, multi-sited organisation. A target consequence of 3 would seem to be a more realistic and achievable target.

As such, it is recommended that the target consequence should be raised to 3, increasing the overall target to 9 which remains within the risk appetite range (3-10).
7. Controls
   a) Key Controls
   A number of controls were put in place to reduce the likelihood and minimise the consequence of this risk and these remain in place. In addition, an integrated monthly performance, quality and finance assurance review is commencing November 2018.

   b) Gaps in control
   As noted earlier, the Trust restructure and governance systems are not fully embedded to realise the widespread improvements to effective decision-making, and the community re-design (iCare) is in early stages with evidenced-based outcomes yet to be identified and delivered.

   In addition, there are:
   - Vacancy levels on some wards and key leadership roles.
   - Insufficient evidence of assurance of systematic clinical supervision across all teams.
   - Insufficient assurance of communication with wards and teams impacting on learning lessons from incidents, complaints etc.
   - Governance systems failing to consistently identify or escalate local practice concerns.
   - New clinical initiatives (R2G and Inpatient Care process models) in early stages of roll out and need embedding.

   Action plans have been developed to address these gaps, most notably the improvement plans agreed by the Board for submission to CQC.

   It should be noted that there is a significant correlation and interdependency with BAF risk 7 (quality and compliance) and BAF risk 14 (patient flow).

8. Assurance
   a) Sources of assurance
   Assurance is provided through:
   - Integrated monthly performance, quality and finance assurance reviews commencing November 2018.
   - Agreed new governance framework for all delivery units.
   - CQC Improvement action plan governance with a CEO-led Portfolio Board, Delivery Board, Oversight and Scrutiny Committee and bi monthly Quality Committees.

   b) Gaps in assurance
   The QI Programme and Performance Management systems are not yet integrated and fully aligned.

   The update and design work to the Performance Management Framework (PMF) to reflect the change to a borough delivery model is undergoing further modification while the development of the new performance report (in Power BI) is being tested with the intention to complete the redesign and transfer reporting over at the end of Q2. The new Director of Performance & Contracts and Programme Management Office has initiated an interim plan and process to produce interim borough-based reports to support PACMAN (Performance and Contract Management) meetings. The new process will:
   - Align with the monthly finance report schedule
   - Provide an opportunity to review reports with Directorates five days before the PACMAN meetings
   - Support the Governance WorkStream in having a PMF process that delivers one monthly performance report that has undergone a robust assurance process with all relevant teams.

9. Conclusion
   This risk remains a significant and relevant strategic risk that should be retained on the BAF.

   The Board is asked to support the following recommendations:
   - Retain the risk on the BAF at the risk rating of 16 (4x4)
   - Increase in the risk target from 6 (likelihood 3 x consequence 2) to 9 (likelihood 3 x consequence 3)
   - Accept the revised BAF risk
   - Note the read across and interdependency to BAF risks 7 (quality and compliance) and 14 (patient flow).
## Annex A: BAF Risk 2: Existing version

**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 then 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.

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<th>Owner:</th>
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### Likelihood

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### Consequence

| Level | 16 | 16 | 6 |  

### Level

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<th>Jun-18</th>
<th>Next review</th>
<th>Sep-18</th>
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### Potential Causes

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.

### 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.

### Sources of Assurance

Performance monitoring KPIs through PACMAN (including DTOC, LoS and other throughput and quality measures such as patient experience). 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.

### Assurance on the effectiveness of Controls

Reports will be made available to QC and FPC for assurance and discussion.

### Request for Closure

No

### 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.

### 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.

### Gaps in Assurance

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.

### Action plan progress summary

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.
Annex B: BAF Risk 2: Proposed revision

Principal Risk 2 (Operational delivery): If the trust does not deliver services from an effective operational structure that provides good leadership and governance or 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.

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<td>Sep-18</td>
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Potential Causes (links to the CRR)

The Trust operational re-structure and supporting governance processes are yet to fully embed and deliver consistent quality leadership and clinical oversight and supervision. Delays in clinical redesign of care pathways and protocols through iCare and the subsequent time to embed and deliver consistent quality. Teams working in new alliance structures and with non SLaM staff are not supported by clear and robust clinical governance frameworks and protocols.

Key Controls

Integrated monthly performance, quality and finance assurance reviews commencing November 2018. 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 management 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. CQC Trust improvement action plan addressing; fundamental standards of care, leadership, governance and patient flow. Individual Directorate action plans to deliver CQC must and should do’s and local implementation of Trust improvement plans. Delivery Board, Oversight and Scrutiny Committee and borough teams in place to oversee implementation plans arising from the CQC report. Following the restructure, the CAGs are currently forming into the Quality Centre and are responsible for the development and monitoring of standardised best practice protocols and the measurement of variation of the clinical practice and outcomes across the Trust.

Sources of Assurance

Integrated monthly performance, quality and finance assurance reviews commencing November 2018. Agreement of new governance framework, monitoring for all delivery units. CQC inspection reports CQC Improvement action plan governance with CEO led Portfolio Board, Delivery Board, Oversight and Scrutiny Committee and bi monthly Quality Committees.

Assurance on the effectiveness of Controls

Integrated monthly performance, quality and finance assurance reviews commencing November 2018. Oversight and Scrutiny Committee. Quality Portfolio Board & reports will be made available to QC for assurance and discussion.

Gaps in Assurance

QI Programme and Performance Management systems are not yet integrated and fully aligned.

Action plan progress summary

Trust wide and individual Operational Directorate improvement plans and governance structures agreed. The improvement plans agreed by the Board for submission to CQC. Delivery Board, Oversight and Scrutiny Committee and Quality Committee will continue to monitor implementation. MADE events action plan in place with first round of Borough events completed.
### Annex C: Consequence score risk descriptors relevant to BAF risk 2

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<th>Domain</th>
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<td>Informal complaint/ inquiry</td>
<td>Formal complaint (stage 1) Local resolution</td>
<td>Formal complaint (stage 2) Local resolution (with potential to go to independent review)</td>
<td>Multiple complaints/ independent review</td>
<td>Inquest/ombudsman inquiry Gross failure to meet national standards. Enforcement action.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Single failure to meet internal standards. Reduced performance rating if unresolved</td>
<td>Repeated failure to meet internal standards</td>
<td>Low performance rating. Critical report.</td>
<td></td>
</tr>
<tr>
<td>Additional examples</td>
<td>Correct and adequate information/ communication on transfer of care</td>
<td>Minor discrepancies to provision of correct and adequate information/ communication on transfer of care</td>
<td>Occasional provision of incorrect or inadequate information/ communication on transfer of care</td>
<td>Frequent provision of incorrect in adequate information/ communication on transfer of care</td>
<td>Continuous provision of incorrect in inadequate information/ communication on transfer of care</td>
</tr>
<tr>
<td>Impact on the safety of patients, staff or public (physical/psychological harm)</td>
<td>Minimal injury requiring no/minimal intervention or treatment.</td>
<td>Minor injury or illness, requiring minor intervention</td>
<td>Moderate injury requiring professional intervention</td>
<td>Major injury leading to long-term incapacity/ disability</td>
<td>Incident leading to death, multiple permanent injuries or irreversible health effects</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Increase in length of hospital stay by 1-3 days</td>
<td>Increase in length of hospital stay by 4-15 days</td>
<td>Increase in length of hospital stay by &gt;15 days</td>
<td>An event which impacts on a large number of patients</td>
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<tr>
<td></td>
<td></td>
<td>Minor mismanagement of patient care with no ill effects</td>
<td>Mismanagement of patient care with short term &amp; treatable effects</td>
<td>Mismanagement of patient care with long-term effects</td>
<td></td>
</tr>
<tr>
<td>Adverse publicity/ reputation</td>
<td>Rumours / potential for public concern</td>
<td>Local media coverage / short-term reduction in public confidence</td>
<td>Local media coverage / long-term reduction in public confidence</td>
<td>National media coverage with &lt;3 days service well below reasonable public expectation</td>
<td>National media coverage with &gt;3 days service well below reasonable public expectation. MP questions in the House. Total loss of public confidence</td>
</tr>
</tbody>
</table>
REPORT TO THE TRUST BOARD: PUBLIC
27 November 2018

<table>
<thead>
<tr>
<th>Title</th>
<th>Quality and Performance Report</th>
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<tbody>
<tr>
<td>Author</td>
<td>Rod Booth, Director of Performance, Contracts &amp; Operational Assurance Mary O’Donovan, Head of Quality</td>
</tr>
<tr>
<td>Accountable Director</td>
<td>Kristin Dominy, Chief Operating Officer Beverley Murphy, Director of Nursing</td>
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</tbody>
</table>

**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 outlines the key issues discussed at the Quality Governance Compliance Meetings (QGCM) against key quality indicators and the key actions proposed, including key risks and issues to flag and points of assurance.

The report provides an update regarding the Performance Management Framework review meetings, current contractual matters arising and the 18/19 Programme Management Office plans (CIP, QIPP and CQUIN).

**Executive Summary:**

This is the second iteration of the joint Quality and Performance Report and is a work in progress to complement Trust Wide work underway on Floor to Board reporting and delivery of Our Improvement Plan which is being implemented in response to the recent CQC review of Trust services. The report includes detail on Length of stay data showing there is work to do on achieving our 35 day target with the next iteration in December 2018 to focus on community caseload activity. To deliver a new ‘Floor to Board’ Quality and Performance Report the Chief Operating Officer and Director of Nursing and Quality will jointly Chair a new series of joint Quality and Performance Meetings during the first two weeks of December 2018. These meetings will receive a new report format that has been reviewed and assured by Teams, Pathway Leads, Directorate Management Teams and Senior Management Team. This new reporting format will be reflected in Quality Committee and Board reports from January 2019 onwards.

There is continuing pressure increase across the adult acute pathway (inpatient and community) resulting in continued usage of external overspill inpatient beds. There are plans in place via the Flow Plan agreed at the previous board meeting to reduce overspill and each borough has a plan in place to reduce overspill to zero and manage within its bed base. Delivery of these plans is reviewed at a weekly meeting Chaired by the Chief Executive.

The Trust is seeing a significant delay in the time taken for services to approve incident reports and therefore make them available for upload onto the external reporting system. Going forward the Quality and Performance meetings will be reviewing individual operational directorate performance data and holding service directors accountable though quality and performance reviews.

At the time of the CQC inspection there had, in the past 12 calendar months, been 36 incidents of patients sleeping in non-designated areas. In the 2 month period post inspection this issue has been tracked closely with 1 incident reported.

The number of reported incidents has increased over the past 4 weeks. Safe organisations typically report higher incident levels and the Trust promotes a culture that records incidents effectively and uses learning to improve quality so this is not an unexpected increase.
QUALITY AND PERFORMANCE REPORT

1. **Report Summary**

2. **NHS Improvement Indicators**
   2.1 Business Intelligence and Trust Information Developments

3. **Operational Performance and Activity**
   3.1 In-Patient Activity and Performance
   3.2 Community Activity & Performance
      3.2.1 Dementia Diagnosis Rates
   3.3 CAMHS Waiting Times

4. **Quality Indicators Compliance**
   4.1 Quality Compliance Indicators - Incidents
   4.2 Process Compliance Indicators - Serious Incident Investigations
   4.3 Compliance Indicator - Patient Experience – Complaints
   4.4 Compliance Indicator – Ligatures
   4.5 Compliance Indicators - Patient Experience – PEDIC Scores
   4.6 Compliance Indicators - Inpatient QUESTT
   4.7 Compliance Indicators – Risk Assessment and Care Plan Audits
   4.8 Right Care Right Time - Quality Improvement/Icare
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   4.10 Staff Recommending The Trust As a Place to Work/Receive Treatment.

5. **Directorate Performance Reviews Summary**
   5.1 Mandatory Training Compliance
   5.1.1 Specific Actions in Relation to Current Areas of Concern

6. **Commissioning**
   6.1 Lambeth and Croydon Alliances
   6.2 Commissioner-related Quality Impact Assessments (QIAs)
   6.3 Commissioning Programmes 2018-19
6.3.1 Quality, Innovation, Productivity and Prevention (QIPP) programme
6.3.2 Commissioning for Quality and Innovation (CQUIN) Schemes

7. Conclusion

Appendix 1 - Glossary

Appendix Document
1. Report Summary
The following areas of the report contain noteworthy risks (detailed performance information is included in the appendices):

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

2. NHS Improvement Indicators
NHS Improvement indicators (Access, Effectiveness and Quality indicators) for the Single Oversight Framework are detailed in Appendix 1 in the Performance and Quality Appendices document. There are no key risks identified for these indicators.

2.1 Business Intelligence and Trust Information Developments
The Patient Flow initiative is the main priority for the BI team and is recognised as needing protected time over the next few months. Working with the Quality Improvement team and Chief Clinical Information Officer (CIO), a list of measures have been defined and an initial prototype developed. To accelerate delivery, the CIO has assisted the Trust Executives by exploring options to increase capacity of the BI Team. Additionally, the BI Team is aligning existing parallel workstreams into a single programme. The major workstreams to be aligned are Deming, Quality Priorities, CQC Enablers and QuESTT.

Community QuESTT continues to evolve and is now receiving input from the Nursing directorate and many of the elements can easily be integrated into Deming during November 2018 alongside the agreed Quality Priorities.

BI has been supporting Performance & Contracts by documenting all the available information reports which have been produced and are available – much of the desire for information has been met and it is clear that increasing the knowledge of and use of existing reports is an immediate opportunity for the Trust.

NHS England has raised an issue relating to the Mental Health Services Data Set submissions in relation to the population of the coding for specialist services. Investigations confirmed NHSE findings and this was due to the outstanding upgrade on the extract mechanism of the clinical system. NHS England wishes to phase out parallel information returns and their due-diligence process requires several months of reconciliation between the two information flows (MHSDS and paper returns). The clinical system itself will be upgraded on the 10th November 2018 and this gives opportunity to permanently resolve the issue this financial year. In the meantime, the BI team has introduced a workaround to populate these data items whilst clinical system supplier addresses the issue.

The next version of the Mental Health Services Data Set (version 4) has confirmed detailed data specifications. This iteration will see an improved focus on employment, carers, restrictive interventions, medication, care plans and indirect activity. The Trust will need to be compliant by April 2019, a gap analysis is being documented, conversations with our system suppliers and NHS England have begun, and the BI team have attended NHS Digital stakeholder events during October 2018.

The Trust still carries risk around the sustainability of the BI Team. The plan to recruit at a lower band and then develop staff has resulted in two new members of staff being recruited (potentially starting in November). However, an experienced member of the team left in September due to the higher rates available outside the NHS.
3. Operational Performance and Activity

3.1 Length of Stay

With a Trust performance focus on patient flow within inpatient wards, Length of Stay (LoS) data for all Borough based adult in-patient wards is set out below for Board information and review (the Average Trust LoS over the past 18 months is 48.5 days against our target of 35 Days).

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.

A review of the Croydon MADE events that were held in September has been conducted to evaluate the impact of the event on the persistent pressure on the Trust’s cost due to external overspills. 49 patients over 50 days Length of Stay (LOS) were reviewed at the event with a total LOS of 11,135 days; 31 have been discharged with a total LOS of 5,389 days, which represents a MADE discharge rate of 61%. This is a significant reduction in bed utilisation equivalent to 179 patients’ worth of beds at an average length of stay of 30 days. It is even more significant considering that the MADE cohort comprises our most stranded patients. However, the 18 remaining from the original cohort include some of our super-stranded patients who may need an alternative approach for discharge. The MADE discharges have also allowed Croydon to repatriate many private and out of area beds, which were not reviewed in the original cohort. A second MADE cycle will be carried out in Croydon in November with the internal event currently planned for 21st November and the external for 28th November.
3.2 Community Activity & Performance
There is persistent increasing pressure in most areas of the community system. Appendix 3 reports on the pressures in A&E Mental Health Liaison and community teams respectively.

3.2.1 Dementia Diagnosis Rates
The national ambition is for a dementia diagnosis rate of 67%. At the time of writing, the performance data for September 2018, was not yet published. However, as reported for August, London diagnosis rate was at 70.9%, with achievements varying between 59.5% to 93.3%. The diagnosis rates for Trust's four boroughs in August:

- Lambeth  76.5%
- Southwark  68.5%
- Lewisham  75.6%
- Croydon  67.8%

3.3 CAMHS Waiting Times
The figures for current cases waiting have been drawn from the CAMHS London data Set and are correct as at end 30 September 2018.

CAMHS waiting times at end of Q2:

<table>
<thead>
<tr>
<th>Borough</th>
<th>52 weeks +</th>
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<tbody>
<tr>
<td>Croydon</td>
<td>5</td>
</tr>
<tr>
<td>Lambeth</td>
<td>11</td>
</tr>
<tr>
<td>Lewisham</td>
<td>96</td>
</tr>
<tr>
<td>Southwark</td>
<td>1</td>
</tr>
</tbody>
</table>

Overall all CAMHS services are experiencing long waits within the neurodevelopmental services.

Croydon has 3 cases within the neuropsychiatry team; all of who have received opt in letters or have an appointment booked. The service is looking at how they can reduce current waiting times of 11 months for this team and have employed a senior psychologist to lead on this work. The further two cases are due to one young person being in a long term inpatient placement and one Looked after children case who has required extensive networking meeting and had DNA’d appointments.

Lambeth has 11 cases all of whom have been risk assessed at referral and sent resource packs to support the young person and family whilst waiting.

Southwark has 1 case which is recording error relating to cases that are for consultation only. BI has been informed and is working to resolve the recording issue.

Lewisham has 96 cases across the generic child and adolescent team (Horizon) and the neurodevelopmental teams. Work is continuing to review and action the cases that should have been closed. In addition the team managers are electronically reviewing all of the cases that have been waiting for longer than 39 weeks to ensure that cases have with a plan to for further action by 12 November. In addition the Deputy Director has requested that there is a senior review of all of the cases on current caseloads to ensure that there are robust plans for these and that we have maximum capacity available within the existing resources. This will allow for planning for further resource requirements to address the waiting times.

The Horizon team has recently reviewed the CAPA approach and have suggested an abridged version of this model in an attempt to improve time from assessment to treatment. This proposal is being considered by the lead clinician and service manager with a view to implementation. Time scales are being planned for this work and will be confirmed by 16 November.
4. Quality Indicators Compliance

This section outlines the compliance and performance against current quality and safety indicators. To note is the reduction in prone restraint being used in Lambeth (fig 11), the improvement in response and investigation timeframes with both complaints and serious incidents. Since July the QuESTTT tool scoring has resulted in an increase in action plans being received and monitored in the monthly Quality governance compliance meetings.

4.1 Patient Safety Quality Indicators

4.1.1 Incidents

The trust is amongst the lowest reporters in England; the aim is to drive up reporting so that we can be sure there is accurate reporting of all patient safety indicators.

NRLS reporting
The Trust is seeing a significant delay in the time taken for services to approve incident reports and therefore make them available for upload onto the national external reporting system. Going forward the Performance and Quality meetings will be reviewing individual operational directorate performance data and holding service directors accountable though quality and performance reviews.

13,112 incidents reported incidents reported on Datix:

<table>
<thead>
<tr>
<th>Severity</th>
<th>Incidents</th>
<th>01/11/17 – 31/10/18</th>
<th>October 2018</th>
</tr>
</thead>
<tbody>
<tr>
<td>A - Death</td>
<td>556</td>
<td>38</td>
<td></td>
</tr>
<tr>
<td>B - Severe</td>
<td>134</td>
<td>21</td>
<td></td>
</tr>
<tr>
<td>C - Moderate</td>
<td>4012</td>
<td>563</td>
<td></td>
</tr>
<tr>
<td>D - Low</td>
<td>5422</td>
<td>396</td>
<td></td>
</tr>
<tr>
<td>E - No Adverse Outcome</td>
<td>2988</td>
<td>215</td>
<td></td>
</tr>
<tr>
<td>Total</td>
<td>13112</td>
<td>1233</td>
<td></td>
</tr>
</tbody>
</table>

The top 5 reported categories were:

<table>
<thead>
<tr>
<th>Category</th>
<th>01/11/17 – 31/10/18</th>
<th>October 2018</th>
</tr>
</thead>
<tbody>
<tr>
<td>Assault By Patient</td>
<td>2441</td>
<td>251</td>
</tr>
<tr>
<td>Challenging Behaviour</td>
<td>1947</td>
<td>192</td>
</tr>
<tr>
<td>Patient Admission</td>
<td>884</td>
<td>62</td>
</tr>
<tr>
<td>Abscond - Sectioned Patient</td>
<td>741</td>
<td>53</td>
</tr>
<tr>
<td>Actual Self-harm</td>
<td>629</td>
<td>68</td>
</tr>
<tr>
<td>Total</td>
<td>6642</td>
<td>626</td>
</tr>
</tbody>
</table>

Fig 2: Total Incidents reported by week, Source; Datix

Fig 3: Total incidents by severity, Source; Datix

Fig 4: Total incidents by top 5 categories Source; Datix
4.1.2 Violence and aggression

Quality priority: Reducing violence by 50% over 3 years

Due to the trust’s focus on restraint, we expect reporting to become more accurate and therefore expect the number of total reported incidents to increase before reducing again.

We are closely monitoring any restraint over 10 minutes in duration and any prone over 5 minutes.
Whilst the graphs above do not show any indicators of change Trust wide, there have been local areas of change which is outlined in the graph below.

![Graph: Number of Prone Restraints in Lambeth services (excluding ES2 on Southwark Site)](image)

**Fig 11: Number of Prone Restraints in Lambeth services (excluding ES2 on Southwark Site)**

This drop in the use of prone restraint was discussed at the Lambeth Quality Governance Compliance meetings. The points below are believed to have contributed to this decrease; it will require further monitoring to establish if this is a shift.

- Improved engagement with 4 steps to safety
- Sharing of good practice of exemplar ward (Luther King Ward)
- Borough Executive oversight on all reported incidents
- Review of PICU admissions - right care setting
- Improved recruitment

### 4.1.4 Incidents of section 136 expiring

![Chart: Total number of s135-s136 overstay - 30.04.18 to 29/10/2018](image)

**Fig 13: Total number of s135-s136 overstay, 30/04/2018-28/10/2018, Source; as reported by Central Place of Safety**
4.1.5 No bed available

No bed available refers to patients returning from AWOL or being admitted to an inpatient ward where a bed is not available. We expect each incident to be reported and patients to be transferred to a ward where they have a bed. In October this occurred on two inpatient wards – in both cases this was due to patients not being discharged from the ward prior to new admissions arriving.

4.1.6 MHA cancellation

All MHA assessments that are cancelled are further categorised to detail the reasons for this. Below is a breakdown of these reasons (October 2018).

<table>
<thead>
<tr>
<th>Type of incident</th>
<th>Count</th>
</tr>
</thead>
<tbody>
<tr>
<td>No Bed - In SLaM</td>
<td>11</td>
</tr>
<tr>
<td>No Police</td>
<td>3</td>
</tr>
<tr>
<td>Patient Not At Home</td>
<td>8</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>22</strong></td>
</tr>
</tbody>
</table>
4.2 Process Compliance Indicators - Serious Incident Investigations

Serious Incidents are small in number and therefore small changes can appear significant when in fact they are simply variance over time. It should be noted that Southwark are very efficient at SI reports.

4.3 Compliance Indicators – Patient Experience – Complaints

Fig. 16: Number of serious incident investigations commissioned
Fig. 17: Average number of days for investigations to be completed

Fig. 18: Number of Formal Complaints received
Fig. 19: Average number of days for complaint responses
In Q2, 14% of complaints were reopened. In Q2, 25 closed complaints were not upheld, 34 were partially upheld and 31 were upheld.

4.4 Compliance Indicators – Patient Experience– PEDIC Scores
**4.5 Compliance Indicators – Inpatient QUESTT**

<table>
<thead>
<tr>
<th>Directorate</th>
<th>Ward</th>
<th>Level 0  (0-9)</th>
<th>Level 1 (10 - 16)</th>
<th>Level 2 (17 - 23)</th>
<th>Level 3(24 - 33)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Lambeth</td>
<td>E12</td>
<td>4</td>
<td>11</td>
<td>12</td>
<td>12</td>
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<td></td>
<td>Camish</td>
<td>7</td>
<td>20</td>
<td>30</td>
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<td>Southwark</td>
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<td>Lambeth</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
</tbody>
</table>

Since July the QuESTT tool scoring has resulted in an increase in action plans being received and monitored in the monthly Quality governance compliance meetings. Lambeth has seen a reduction of wards scoring high, whilst Croydon has seen an increase. The process of data submission and action plans has been smoother since the Trust restructure into Boroughs. Notably in September Eden Ward did not trigger and this was in part due to the reduction of the use of 1-1 obs. There has been a local training package in place and escalation plan in place.
4.6 Compliance Indicators – Risk Assessment and Care Plan Audits

The above charts demonstrate an improvement since October 2017, however there has been a decrease since June 2018 in the audit scores relating to care plans being devised collaboratively, which could coincide with the reduction in the number of audits being carried out. The reduction in number was agreed following the audit prioritisation in other areas such as rapid tranquilisation monitoring. The Nursing executive are currently reviewing all the SNAP audit tools to ensure standardisation in both use and scope.

4.7 Right Care Right Time – Quality Improvement/ICare

4.7.1 All patients will have access to the right care at the right time in the appropriate setting

Fig 26: Right care at right time; Readmissions within 30 days- Source; Trust Dashboard
4.7.2 All patients will have access to the right care at the right time in the appropriate setting

The waited time within the Trust dashboard is currently measuring all community service types.

Icare continues to contribute to the overall improvement plan and was presented as part of the October board report in relation to QI. The QI team are also in the process of drafting an information “leaflet” about the Icare work as some staff are unclear about the work, this will be coproduced and be accessible electronically (on Maud) and paper

4.8 Staff Turnover

The staff experience indicators and quality improvement workstreams are also monitored in the Trustwide workforce and equalities committee.

Fig. 27: Right care at right time; Community Services Average Waited Time - Source; Trust Dashboard

Fig. 28: Reduce staff turnover; Source; Trust Dashboard
4.9 Staff recommending the Trust as a place to work/receive treatment

The Trust has set a quality priority to increase to 75% the proportion of staff recommending the Trust as a place to work. The Trust captures this information annually through the national Staff Survey and takes quarterly temperature checks through the Staff Friends and Family Test (FFT).

<table>
<thead>
<tr>
<th>FFT Question</th>
<th>Quality Committee Staff Experience target</th>
<th>Original Baseline</th>
<th>2018 Quarter 1 response</th>
<th>2018 Quarter 2 response</th>
</tr>
</thead>
<tbody>
<tr>
<td>How likely are you to recommend this organisation to friends and family if they needed care or treatment?</td>
<td>75% (over 3 years)</td>
<td>61% (national survey)</td>
<td>72%</td>
<td>68%</td>
</tr>
<tr>
<td>How likely are you to recommend this organisation to friends and family as a place to work?</td>
<td>75% (over 3 years)</td>
<td>60% (national survey)</td>
<td>63%</td>
<td>60%</td>
</tr>
</tbody>
</table>

**Fig. 29: Staff survey results; Source: Staff Friends and Family Test**

The Trust has set a target to reduce turnover by 10% over a three-year period. Actions to deliver this significant improvement were presented to the Board in May in a deep dive into BAF Risk 1 on recruitment and retention and include:

- Getting the basics right
- Improving recruitment processes
- Improving staff engagement
- Enhancing the training and development offer
- Redesigning roles
- Developing our approach to talent management
- Targeted recruitment campaigns
- Improved preceptorship for newly qualified nurses
- SLP Nurse development programme offering competence-based career progression for nursing staff
- Career progression for health care support workers through Nursing Associates and Assistant Practitioners
- Nurse degree and other apprenticeships
- Passport offering ease of transfer between SLP partner Trusts.
5. **Directorate Performance Reviews Summary**

The focus of the Performance Team during the past month has been to deliver a Joint Performance, Quality, Finance and Workforce reporting framework to support and complement delivery of the CQC Trust Improvement Plan. Dates for the first Operational Directorate assurance meetings under this new framework will take place in the first two weeks of December and be jointly Chaired by the Chief Operating Officer and Director of Nursing and Quality.

This new framework is being delivered under the Governance Workstream of Our Improvement Plan and will ensure that the same data set and service narrative is considered by local delivery Teams through to Board. The format of the Joint Performance and Quality Board Report will develop during Q4 2018/19 in line with this focus on quality improvements, patient flow and CCG constitutional standards. This will include a new presentation for length of stay data and reflect on learning from implementation of new daily and weekly Trust Dashboards.

The past month also saw delivery of a detailed action tracker for CQC must and should do actions and wider Trust plans on Leadership and Culture, Governance, Patient Flow and Fundamental Standards of Care. This tracker will ensure the Trust is able to performance manage and assure delivery of actions in a robust manner putting in place mitigating actions against risk areas as necessary.

5.1 **Mandatory Training Compliance**

Overall compliance has fallen slightly in October from 87.35% to 86.70%. One factor depressing overall compliance is that during the appraisal season, many staff who are appraisers but not managers need to have their job roles temporarily changed on LEAP to enable them to access the appraisal system. This temporary adjustment means that these staff will temporarily have Health and Safety for Managers, Risk Management and Clinical Supervision appearing on their LEAP profiles as being non-compliant which in turn affects the compliance information. Once the HR Business Partners have completed the calibration process, this will be put right. There is work planned with the providers of LEAP to streamline the ‘change manager’ process and access to the appraisal system on LEAP so it is anticipated that this issue will be resolved in time for the next round of appraisals. Current compliance by directorate and by subject matter is shown in Appendix 5 of the Appendices document.

5.1.1 **Specific Actions in Relation to Current Areas of Concern**

- **Immediate Life Support**
  
  There has been a 6% fall in Immediate Life Support. As ILS needs to be refreshed annually and autumn is a period when we traditionally have a large intake of newly qualified nurses, a larger number of staff than usual have fallen out of compliance in October. The capacity to provide ILS courses has also dropped, through a combination of a tutor leaving, his replacement seconded to do MEWS training, and another on an extended phased return to work after long term sickness absence. We are buying in external trainers to increase capacity, though this doubles the cost of the training. ILS trainers also deliver PSTS training, a competing priority.

- **PSTS**

  PSTS has virtually remained static but there are long wait lists. As this is the peak time of the year for newly qualified registered nursing staff commencing in the Trust, we have put on additional PSTS teamwork training. Again, the loss of the seconded tutor and the tutor currently not delivering training, impacts on our ability to sustain additional PSTS training and also impacts on the quality of training.
- **Reducing the burden of mandatory training**

  Work is continuing to review what we expect of staff, and how we deliver training, so that we can make keeping staff safe as efficient as possible. Recommendations made as a result of comparisons with the training requirements set by our SLP partners need to be reflected in policy changes, and in some cases, need a new approach to be adopted by subject matter experts. This work is being led by the Director of Nursing and supported by the E&D team.

6. **Commissioning**

A South London Partnership (SLP) bid to SEL and SWL STP commissioners was successful in attracting a £1.24m investment into SLP partner winter plans. For SLaM, this investment is being used to support additional bed capacity at ELFT, Social Care Discharge Teams, Risk Forums and enhanced Liaison Teams in Emergency Departments. These developments complement and are part of wider Trust plans agreed at the previous Board meeting to improve patient flow.

Monthly contract meetings continue to be held with 4 Borough commissioners and quarterly with NHSE commissioners to review activity and financial performance. In line with annual practice, projections on cost and volume activity and risk share levels on any overperformance are being shared with commissioners to support 2018/19 closedown. South East London STP is also undertaking a Commissioner and Provider alignment exercise to ensure all system partners are agreed on the level of activity delivered and any risk this poses to achieve an end of year financial balance. The level of activity delivered by the Trust and any associated demand above commissioned capacity is being shared as part of this exercise.

All QIPP and investment schemes are reviewed at contract meetings. A particular QIPP of note is the closure of Ann Moss in Southwark which was delivered earlier than target with quality pathway improvements and efficiencies fully realised. Mental Health Investment Standard developments have been agreed across the 4 Commissioning Boroughs with a risk review in place to ensure commissioner funding is allocated and spent in line with agreements prior to year-end.

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 has reduced its adult placements budget in 2018/19 by £1m to £2.1 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 Council and Southwark CCG. It should be noted the initially proposed reduction in CAMHS services, then withdrawn was also £1m.
6.1 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. Work has been successfully delivered on a new housing step down / recovery model with 6 new flats opening in January 2019 to support discharge from in-patient wards. Work also continues to develop with Black Thrive partners in Lambeth to support data requirement on ethnicity.

The Croydon Alliance is now moving into a new phase of delivering Primary Care Hubs with SLaM front and centre with its new GP Advice Line service. This aligns with the alliance moving from older adults into a general population / all ages model.

6.2 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.

6.3 Commissioning Programmes 2018-19
2018-19 QIPP and CQUIN schemes are being managed using the PMO principles.

6.3.1 Quality, Innovation, Productivity and Prevention (QIPP) programme
The QIPP risk dashboard and CIP chart are in Appendix 6 of the appendices document. 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>1,169</td>
</tr>
<tr>
<td>Green</td>
<td>Requires little work</td>
<td>5,409</td>
</tr>
<tr>
<td>Total</td>
<td></td>
<td>8,504</td>
</tr>
</tbody>
</table>

The QIPP position at month 6 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.

**Amber Risks**
- **SHARP. Value £400k.** £400k QIPP & £133k CIP removed from annual budget. However, M6 budget confirms variance of £49k. This overspending has reduced compared to the beginning of the year, improvement seen in Month 6. 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 M6
- **QIPP Triage savings. Value £200k.** This QIPP is amber because Implementation of this initiative is in delay, which is due to delay in seeking QIA approval.

6.3.2 **Commissioning for Quality and Innovation (CQUIN) Schemes**
The national CQUINs for 18/19 are same as 17/18, being the second year of implementation in the two-year contract cycle signed for 17/19.

In October, most of the Quarter 2 reports were submitted to commissioners and extension sought and granted for CQUIN 4: A&E Frequent attenders and CQUIN 5 CAMHS – Transitions into AMH. Flu clinics, in fulfilment of CQUIN 1c, have commenced across the Trust, and notification published in the Trust’s Communications e-letter.

CQUIN 3a: Data has been collected for the EIP outcome indicators. This is currently being collected quarterly and plans to share this data with EIP teams are underway. Trust’s representative attended a Southwark commissioner meeting on 25th October, to discuss concerns and progress plans around CQUIN 3b and trust now awaiting feedback from commissioners. Croydon and Lewisham have not completed the reconciliation, due to lack of commitment from primary care services. A new draft shared care protocol has been developed by the clinical leads and shared with Commissioners as part or quarter 2 report. This is currently in the process of being agreed with primary care services via the clinical leads for each borough. The Chief Clinical Information Officer (CCIO) has agreed to provide a statement for the interoperability of data and IT systems between secondary and primary care. This should be ready for quarter 3 submission to commissioners.

CQUIN 9abc: During quarter 2, the efforts to maintain a strong focus on tackling tobacco dependence has been sustained. The Trust Physical Health Strategy has been launched in Lambeth and Lewisham, with local plans now in development to address areas requiring improvement. Staff have been instructed to recognise tobacco dependence as an urgent clinical condition requiring access to
evidence-based interventions and to support our care environment that is conducive to cutting down and quitting. Trust believes this has been achieved.

CQUIN 9de: A revised brief advice leaflet has been developed in a format that it is hoped will enable brief advice to be more readily provided. Alcohol Awareness Week (November 19th-25th) which falls within Q3, and Dry January, which falls within Q4, provide opportunities for focusing on alcohol screening and interventions. The slogan ‘Don’t just screen – intervene’ is being used to encourage staff to build upon screening and deliver the appropriate interventions. Posters promoting this message with prompts regarding the appropriate interventions are being produced for the wards.

NHSE CQUIN Q2 milestone requirements were successfully submitted and expected to deliver full achievement. We are now awaiting feedback from NHSE to confirm achievement for this period.

7. 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. A review of the Croydon MADE events that were held in September has been conducted to evaluate the impact of the event on the persistent pressure on the Trust’s cost due to external overspills. Of the 49 patients reviewed, 31 have been discharged. A second cycle of the Croydon MADE events is planned for November.

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.
# Appendix 1 - Glossary

<table>
<thead>
<tr>
<th>Abbreviation</th>
<th>Description</th>
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<tbody>
<tr>
<td>AEP</td>
<td>Accountable Emergency Officer</td>
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<tr>
<td>AfC</td>
<td>Agenda for Change</td>
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<tr>
<td>Ascom</td>
<td>Alarm / communications system supplied by Ascom UK, a telecommunications company</td>
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<tr>
<td>ASD / LD</td>
<td>Autism Spectrum Disorder / Learning Disability</td>
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<tr>
<td>CAG</td>
<td>Clinical Academic Group – bringing together clinical services, research and education and training into a single management grouping e.g. Psychosis</td>
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<tr>
<td>CAMHS</td>
<td>Child and Adolescent Mental Health Services</td>
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<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>
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<tr>
<td>CHS</td>
<td>Croydon Health Services NHS Trust</td>
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<tr>
<td>CPA</td>
<td>Care Programme Approach</td>
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<tr>
<td>CQUIN</td>
<td>Commissioning for Quality and Innovation: A fund where payment is contingent on delivery on quality improvements and meeting milestones agreed with commissioners.</td>
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<tr>
<td>CYP</td>
<td>Children &amp; Young People</td>
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<tr>
<td>DBT</td>
<td>Dialectical Behaviour Therapy</td>
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<tr>
<td>DTOC</td>
<td>Delayed Transfers of Care</td>
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<tr>
<td>E&amp;D</td>
<td>Education &amp; Development Department</td>
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<tr>
<td>EI</td>
<td>Early Intervention: First Episode Psychosis</td>
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<tr>
<td>ePJS</td>
<td>Electronic Patient Journey System: Clinical records system</td>
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<tr>
<td>EPM</td>
<td>Emergency Planning Manager</td>
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<tr>
<td>EPRR</td>
<td>Emergency Preparedness, Resilience and Response</td>
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<tr>
<td>GSTT</td>
<td>Guys &amp; ST Thomas’ NHS Foundation Trust</td>
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<tr>
<td>HTT</td>
<td>Home Treatment Team</td>
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<tr>
<td>IAPT</td>
<td>Improving Access to Psychological Therapies</td>
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<tr>
<td>JOSC</td>
<td>Joint Overview and Scrutiny Committee</td>
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<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>
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<tr>
<td>LSLC</td>
<td>Lambeth, Southwark, Lewisham &amp; Croydon (CCGs)</td>
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<tr>
<td>LTC</td>
<td>Long Term Condition</td>
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<tr>
<td>MHOAD</td>
<td>Mental Health of Older Adults and Dementia</td>
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<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>
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<tr>
<td>NHSE</td>
<td>NHS England</td>
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<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>
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<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>
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<tr>
<td>OAP</td>
<td>Out of Area Placement</td>
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<tr>
<td>OBD</td>
<td>Occupied Bed Day – is a unit of currency used to measure the use made of a bed (e.g. 1 obd = 1 bed occupied for 1 day by a patient)</td>
</tr>
<tr>
<td>PACMAN</td>
<td>Performance and Contract Management (meeting)</td>
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<tr>
<td>PICU</td>
<td>Psychiatric Intensive Care Unit</td>
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<tr>
<td>PMF</td>
<td>Performance Management Framework</td>
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<tr>
<td>PMO</td>
<td>Programme Management Office</td>
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<tr>
<td>QIA</td>
<td>Quality Impact Assessment</td>
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<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>
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<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>
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<tr>
<td>SPC</td>
<td>Statistical Process Control</td>
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<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>
Appendix 1: NHS Improvement indicators (Access, Effectiveness and Quality indicators)
- Home Treatment Team Gatekeeping
- Early Intervention in Psychosis 2-week standard
- IAPT Waiting Times
- IAPT Recovery
- Seven Day Follow Up

Appendix 2: Operational Performance and Activity
- In-Patient Activity and Performance
- LSLC Admissions
- Delayed Transfers of Care

Appendix 3: Community Activity & Performance
- A&E Mental Health Liaison
- Community Teams

Appendix 4: Mandatory Training Compliance
- Current Compliance Rates

Appendix 5: Quality, Innovation, Productivity and Prevention (QIPP) programme
- Cost Improvement Programme (CIP)
Appendix 1: NHS Improvement indicators (Access, Effectiveness and Quality indicators)

- Home Treatment Team Gatekeeping

![HTT Gatekeeping Graph]

**Fig. 1 NHSI Indicators: HTT Gatekeeping.**
The Trust achieved performance of 98% in August as it continues to exceed the 95% target and plan is to maintain this performance level.

- Early Intervention in Psychosis 2-week standard

![El 2 week standard Graph]

**Fig. 2 NHSI Indicators: Early Intervention in Psychosis**
The Trust achieved 67% as it continues to exceed the 53% target for 2018/19 Early Intervention waiting time standard.
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 red line in the chart, the most recent data being July 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.
Trust maintains its high aggregate achievement for the 6 week standard at 92% in September, with similar high 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 July 2018.

Southwark IAPT received £300k at the end of September to fund additional resource required to meet the national access target of 19% by the last quarter of 2018/19. A new publicity strategy has been launched at King’s College Hospital (KCH) and Guy’s & St. Thomas’ Hospital (GSTT) to increase the number of referrals from patients with long-term physical health conditions. The service has increased first consultation capacities in order to meet the new access target.

Lambeth Talking Therapies Services achieved an access rate of 17.6% in Q2, against a commissioned target of 16.8%. Recovery rate was 48%, marginally below the national target of 50%. Waiting times are well below national targets, with 96% seen within 6 weeks (75% target) and 100% within 18 weeks (95% target) for first treatment session (triage).

There is currently no agreed plan in place with CCGs regarding achievement of 25% access target by 2020/2. Although the CCG has provisionally approved some additional funding for Quarter 4, (Jan- Mar 2019), this will not be sufficient to raise the service from the previous 15.2% to reach 19% access for the full 2019 year. Other areas of major constraints include staffing, accommodation and funding. In the absence of investment in increasing provision for clients with long term conditions (LTCs), incremental development of service model is taking place, with initial focus on diabetes. Overall, the service is reviewing how it can tailor its treatment offer to the capacity that is funded, which may mean offering treatment to fewer clients.

Access to Lewisham IAPT services is continuing to increase, with the highest number of referrals to the service occurring in October at 1191. Service is on track to make the 19% access in Q4 as it remains well above target, achieving 17.7% at Q2. However this hampers the development of
services for LTCs as more resources are being diverted to screening and triage. Nevertheless, some new activities are planned for Q4 piloting small collaborative services with targeted GP practices around COPD and diabetes.

- **IAPT Recovery**

![IAPT Recovery Rate graph](image)

### Fig. 5 NHSI Indicators: IAPT Recovery Rate – aggregate and detail

Trust achieved the IAPT recovery rate at 51.87% in September 2018, above the 50% target. Croydon, Lewisham and Southwark services achieved the targets at 52.73%, 56.4% and 50.8% respectively, while Lambeth services performed marginally below the 50% target rate at 48.14%.
• Seven Day Follow Up

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

Performance remains low at September due to the small number of caseloads and small number of missed follow up recorded. 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.

• Community Wait Times

Community wait times reports on the length of time that service users had to wait for their first face-to-face contact with services following initial referral, and the number of service users still waiting after 12 months. Lewisham CAMHS remains at the highest level of waits over 12 months at 162 patients at the time of reporting; a significant drop from the 254 patients reported in October’s report. Croydon’s Personality Disorders and Psychological Therapies has marginally dropped to 121 patients from 150 patients but remains high and Southwark Psychological Therapies remains high at 142 patients.

<table>
<thead>
<tr>
<th>Patients still Waiting (over 12 months) 2018/19</th>
<th>Croydon</th>
<th>Lambeth</th>
<th>Lewisham</th>
<th>Southwark</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Acute Care Pathway</td>
<td>2</td>
<td></td>
<td>2</td>
<td></td>
<td>4</td>
</tr>
<tr>
<td>Addictions</td>
<td>24</td>
<td>2</td>
<td></td>
<td></td>
<td>26</td>
</tr>
<tr>
<td>Child and Adolescent Mental Health Services</td>
<td>9</td>
<td>18</td>
<td>162</td>
<td>2</td>
<td>191</td>
</tr>
<tr>
<td>MHOA and Dementia</td>
<td>1</td>
<td>15</td>
<td>1</td>
<td></td>
<td>17</td>
</tr>
<tr>
<td>Psychological Medicine &amp; Integrated Care</td>
<td>121</td>
<td>57</td>
<td>14</td>
<td>142</td>
<td>334</td>
</tr>
<tr>
<td>Psychosis</td>
<td>7</td>
<td>27</td>
<td>5</td>
<td>43</td>
<td>82</td>
</tr>
<tr>
<td>Total</td>
<td>138</td>
<td>143</td>
<td>182</td>
<td>189</td>
<td>652</td>
</tr>
</tbody>
</table>

Fig 7. Patients waiting over 12 months
Croydon psychological therapies service waiting times for CAT assessments continue to be affected by long term staff sickness. From November 2018, CAT assessment slots will be made available from other modalities and assessed by senior Psychologists and Psychodynamic Psychotherapists to help reduce the wait time. Psychodynamic waiting times and numbers have fallen significantly with new fixed-term post holders having commenced. The initiative predicts that waiting times at the end of the fixed term posts (August 2019) will be at 2 years and the audit is underway.

Appendix 2: Operational Performance and Activity

- 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 (El, 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 September 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).
Fig. 8 – LSLC Acute, EI and PICU performance against commissioned trajectory

Fig. 9 – External Overspill, August 2017 through to end of September 2018
Fig. 10 – Length of Stay Breakdown

Figure 10 clusters the inpatient cohort within the acute care pathway (wk1, November) 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 maintains the highest number of inpatients whilst both Croydon and Lambeth continue to have a high proportion of patients with longer lengths of stay.

- **LSLC Admissions**
  The following charts show the admissions by CCG for each month Apr 17 – September 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. There was broadly a marginal fall in actual performance of admission levels in September 2018 except Lambeth where admission levels increased above planned levels.
Fig. 11 – LSLC Admissions by month

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

In September, the Trust recorded 572 bed days lost due to delayed transfers of care. This represents a 3% loss, which is slightly below the 3.5% target set from September 2017 by NHSE.

Fig. 12 – Delayed Transfer of Care lost bed days by month

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 is according to NHS England guidance and attribution process agreed in consultation with local authorities.
Appendix 3: Community Activity & Performance

- **A&E Mental Health Liaison**
  The number of presentations to A&E Mental Health Liaison teams was quite high and above plan for Lambeth and Southwark teams; Croydon was at plan whilst Lewisham was marginally below plan.
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 September indicating continued growth in the caseload size of our Home Treatment and marginal reduction in that of the Early Intervention teams. The updated information to September 2018 is shown in Figs. 15 and 16.
Fig. 15 Adult Home Treatment Team caseload, referrals and discharges Apr 16 – September 18

Fig. 16 Early Intervention caseload, referrals and discharges Apr 16 – September 18
### Appendix 4: Mandatory Training Compliance

#### Current Compliance Rates

<table>
<thead>
<tr>
<th>Directorate</th>
<th>September 2018</th>
<th>October 2018</th>
</tr>
</thead>
<tbody>
<tr>
<td>Child &amp; Adolescent Services</td>
<td>88.74%</td>
<td>88.73%</td>
</tr>
<tr>
<td>Clinical Support Services</td>
<td>73.47%</td>
<td>70.90%</td>
</tr>
<tr>
<td>Corporate Directorate</td>
<td>83.28%</td>
<td>81.83%</td>
</tr>
<tr>
<td>Croydon Directorate</td>
<td>90.37%</td>
<td>89.66%</td>
</tr>
<tr>
<td>Lambeth Directorate</td>
<td>84.29%</td>
<td>83.29%</td>
</tr>
<tr>
<td>Lewisham Directorate</td>
<td>88.74%</td>
<td>88.80%</td>
</tr>
<tr>
<td>PMOA</td>
<td>88.79%</td>
<td>89.48%</td>
</tr>
<tr>
<td>Southwark Directorate</td>
<td>87.39%</td>
<td>85.94%</td>
</tr>
<tr>
<td><strong>Grand Total</strong></td>
<td><strong>87.35%</strong></td>
<td><strong>86.70%</strong></td>
</tr>
</tbody>
</table>

**Fig. 17 – Mandatory training compliance rate by directorate**

<table>
<thead>
<tr>
<th>Core Subjects (Target 85%)</th>
<th>April 2018</th>
<th>July 2018</th>
<th>October 2018</th>
</tr>
</thead>
<tbody>
<tr>
<td>Basic Life Support – Group 1</td>
<td>90.57%</td>
<td>94.17%</td>
<td>95.21%</td>
</tr>
<tr>
<td>Basic Life Support - Group 2</td>
<td>66.57%</td>
<td>81.94%</td>
<td>81.64%</td>
</tr>
<tr>
<td>Equality, Diversity and Human Rights</td>
<td>87.64%</td>
<td>92.25%</td>
<td>90.98%</td>
</tr>
<tr>
<td>Fire Safety Awareness</td>
<td>80.78%</td>
<td>90.19%</td>
<td>86.14%</td>
</tr>
<tr>
<td>Health, Safety and Welfare</td>
<td>86.13%</td>
<td>90.19%</td>
<td>88.18%</td>
</tr>
<tr>
<td>Immediate Life Support [1 Year]</td>
<td>70.80%</td>
<td>78.99%</td>
<td>73.16%</td>
</tr>
<tr>
<td>Infection Control Level 1</td>
<td>89.46%</td>
<td>93.29%</td>
<td>91.98%</td>
</tr>
<tr>
<td>Infection Control Level 2</td>
<td>70.04%</td>
<td>79.47%</td>
<td>81.77%</td>
</tr>
<tr>
<td>Information Governance</td>
<td>78.70%</td>
<td>83.74%</td>
<td>86.03%</td>
</tr>
<tr>
<td>Moving and Handling - Loads - Group 1</td>
<td>91.24%</td>
<td>89.29%</td>
<td>97.69%</td>
</tr>
<tr>
<td>Moving and Handling - Loads - Group 2</td>
<td>78.57%</td>
<td>95.83%</td>
<td>95.65%</td>
</tr>
<tr>
<td>Moving and Handling - Loads - Group 3</td>
<td>87.15%</td>
<td>92.03%</td>
<td>91.55%</td>
</tr>
<tr>
<td>Moving and Handling - Patients - Group 1</td>
<td>73.23%</td>
<td>83.06%</td>
<td>87.50%</td>
</tr>
<tr>
<td>Moving and Handling - Patients - Group 2</td>
<td>84.84%</td>
<td>90.19%</td>
<td>92.22%</td>
</tr>
<tr>
<td>Moving and Handling - Patients - Group 3</td>
<td>82.05%</td>
<td>94.74%</td>
<td>93.37%</td>
</tr>
<tr>
<td>Prevent Awareness</td>
<td>89.52%</td>
<td>93.03%</td>
<td>90.44%</td>
</tr>
<tr>
<td>Prevent Workshop</td>
<td>86.67%</td>
<td>90.43%</td>
<td>86.15%</td>
</tr>
<tr>
<td>PSTS Awareness/Conflict Resolution</td>
<td>79.66%</td>
<td>84.47%</td>
<td>86.15%</td>
</tr>
<tr>
<td>PSTS Disengagement</td>
<td>66.72%</td>
<td>74.42%</td>
<td>74.72%</td>
</tr>
<tr>
<td>PSTS Team Work</td>
<td>81.43%</td>
<td>86.06%</td>
<td>87.48%</td>
</tr>
<tr>
<td>Safeguarding Adults Alerters</td>
<td>85.66%</td>
<td>90.01%</td>
<td>89.87%</td>
</tr>
<tr>
<td>Safeguarding Adults Alerters Plus</td>
<td>85.20%</td>
<td>89.69%</td>
<td>86.69%</td>
</tr>
<tr>
<td>Safeguarding Children Level 1</td>
<td>87.63%</td>
<td>91.93%</td>
<td>91.99%</td>
</tr>
<tr>
<td>Safeguarding Children Level 1 and 2</td>
<td>94.10%</td>
<td>97.54%</td>
<td>96.97%</td>
</tr>
<tr>
<td>Safeguarding Children Level 3</td>
<td>80.58%</td>
<td>88.80%</td>
<td>89.79%</td>
</tr>
<tr>
<td><strong>Grand Total</strong></td>
<td><strong>81.94%</strong></td>
<td><strong>87.08%</strong></td>
<td><strong>86.70%</strong></td>
</tr>
<tr>
<td>Non-core – Mental Health Specific Subjects</td>
<td>April 2018</td>
<td>July 2018</td>
<td>October 2018</td>
</tr>
<tr>
<td>-------------------------------------------</td>
<td>-----------</td>
<td>-----------</td>
<td>--------------</td>
</tr>
<tr>
<td>Deprivation of Liberty Safeguards (DoLS) [3 Years]</td>
<td>84.95%</td>
<td>89.99%</td>
<td>86.85%</td>
</tr>
<tr>
<td>Mental Capacity Act (MCA) [3 Years]</td>
<td>85.72%</td>
<td>90.47%</td>
<td>85.89%</td>
</tr>
<tr>
<td>Mental Health Act Training [3 Years]</td>
<td>84.71%</td>
<td>88.44%</td>
<td>85.41%</td>
</tr>
</tbody>
</table>

**Fig. 18: Mandatory training compliance rates by subjects**
Appendix 5: Quality, Innovation, Productivity and Prevention (QIPP) programme

- 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>418</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>266</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>112</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>Yellow</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>55</td>
<td>Green</td>
<td>0</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>Green</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>
<tr>
<td>LEW-1819-005-Q</td>
<td>Lewisham</td>
<td>QIPP Triage savings</td>
<td>Implementation in June 18</td>
<td>200</td>
<td>Yellow</td>
<td>33</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>55</td>
<td>Green</td>
<td>0</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>40</td>
<td>Green</td>
<td>0</td>
</tr>
<tr>
<td>LAM-1819-006-Q</td>
<td>Lambeth</td>
<td>ASD &amp; ADHD C&amp;V expenditure</td>
<td>QIPP being achieved subject to CCG confirmation.</td>
<td>150</td>
<td>Green</td>
<td>0</td>
</tr>
<tr>
<td>PMOA-1819-011-Q</td>
<td>Lambeth</td>
<td>Greenvale - reduction in beds</td>
<td>QIPP being achieved</td>
<td>666</td>
<td>0</td>
<td></td>
</tr>
<tr>
<td>PMOA-1819-010-Q</td>
<td>Southwark</td>
<td>Ann Moss Way</td>
<td>Service improvement</td>
<td>893</td>
<td>0</td>
<td></td>
</tr>
<tr>
<td>LEW-1819-007-Q</td>
<td>Lewisham</td>
<td>FYE - IAPT (15% reduction)</td>
<td>QIPP being achieved</td>
<td>93</td>
<td>0</td>
<td></td>
</tr>
<tr>
<td>LEW-1819-011-Q</td>
<td>Lewisham</td>
<td>FYE - LITT Team - move from Psychosis to primary (PMIC link)</td>
<td>QIPP being achieved</td>
<td>43</td>
<td>0</td>
<td></td>
</tr>
<tr>
<td>CRY-1819-010-Q</td>
<td>Croydon</td>
<td>Croydon Adult inpatient - baseline as per 17/18</td>
<td>OBD are within the plan and QIPP should be achieved (based M1 performance)</td>
<td>2,333</td>
<td>155</td>
<td></td>
</tr>
<tr>
<td>CEN-1819-017-Q</td>
<td>NHSE</td>
<td>NHSE Specialist Contracts</td>
<td>QIPP offset by investment - 17/18 baseline has therefore been retained</td>
<td>1,136</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>TOTAL</strong></td>
<td></td>
<td></td>
<td></td>
<td><strong>8,504</strong></td>
<td><strong>1054</strong></td>
<td></td>
</tr>
</tbody>
</table>

Fig. 19: QIPP dashboard

- **Cost Improvement Programme (CIP)**
<table>
<thead>
<tr>
<th>Risk</th>
<th>CAMHS</th>
<th>Central</th>
<th>Croydon Hub/Quality centre</th>
<th>Lambeth</th>
<th>Lewisham</th>
<th>PMOA</th>
<th>Southwark</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>HIGH</td>
<td>191</td>
<td>2,099</td>
<td>514</td>
<td>211</td>
<td></td>
<td>161</td>
<td>1,986</td>
<td>5,162</td>
</tr>
<tr>
<td>M</td>
<td>813</td>
<td>1,671</td>
<td>79</td>
<td>1,463</td>
<td>385</td>
<td>262</td>
<td>487</td>
<td>5,350</td>
</tr>
<tr>
<td>LOW</td>
<td>230</td>
<td>4,358</td>
<td>70</td>
<td>758</td>
<td>55</td>
<td>345</td>
<td>487</td>
<td>5,816</td>
</tr>
<tr>
<td>Total</td>
<td>1,234</td>
<td>8,128</td>
<td>149</td>
<td>2,735</td>
<td>401</td>
<td>768</td>
<td>2,473</td>
<td>16,328</td>
</tr>
</tbody>
</table>

**Fig. 20: Trust M6 CIP position**

The chart above shows the summary of the Trust CIP schemes broken down by Operational Delivery Unit (ODU) and by risk as at M6. The table shows that of the 66 schemes at £16.4m in the Trust plan, £5.1m are at high risk. This is driven primarily by bed costs (overspill). £5.3m is rated medium for risk, driven primarily by overspends in inpatient nursing. The remaining £5.8m is rated as low risk.
REPORT TO THE TRUST BOARD: PUBLIC
27 November 2018

<table>
<thead>
<tr>
<th>Title</th>
<th>Research and Development Strategy Update</th>
</tr>
</thead>
<tbody>
<tr>
<td>Author</td>
<td>Fiona Gaughran (R&amp;D Director) and Gill Dale (Director of Research Quality)</td>
</tr>
<tr>
<td>Accountable Director</td>
<td>Michael Holland – Medical Director</td>
</tr>
</tbody>
</table>

Purpose of the paper

This is the annual R&D report to the Board, and following approval of the R&D Strategy at the Board in November 2017, now comprises a report on progress against this Strategy. This is for the Board to discuss and note.

Executive summary

The R&D Strategy was agreed by the Board in November 2017. This paper summarises progress over the last year in the key strategic areas identified in the R&D Strategy document, also describing some remaining challenges, risks and areas for further development.

The paper reports on progress in the following R&D strategic areas:
- R&D embedded as core Trust business
- Strategic use of R&D funding
- Building SLaM’s research workforce
- Enhancing R&D income opportunities
- Recruitment of SLaM service users into research studies
- PPI involvement
- Acknowledgement of SLaM on research publications and media communications
- R&D Governance and management

Positive feedback from the CQC acknowledged the progress with implementing the R&D Strategy and the impact of research outcomes on clinical care.

Risks / issues for escalation

There are no BAF risks for R&D.

Committees where this item has been considered

<table>
<thead>
<tr>
<th>Date</th>
<th>Committee / Meeting</th>
</tr>
</thead>
<tbody>
<tr>
<td>22 Nov 2018</td>
<td>R&amp;D Committee</td>
</tr>
</tbody>
</table>
1. Introduction

The R&D Strategy was agreed by the Board in November 2017. This paper summarises progress over the last year in the key strategic areas identified in the R&D Strategy document, also describing some remaining challenges and areas for further development.

2. R&D Strategic Areas

The following table from the R&D Strategy document identified R&D strategic areas and how progress would be measured:

*Measuring progress – metrics and milestones (from R&D Strategy, November 2017):*

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

(i) R&D embedded as core Trust business
SLaM is recognised as being a leading research-active Trust, largely as a result of our close partnership with IoPPN, where most of the research leadership sits. Whilst acknowledging this positive position, the R&D Strategy also seeks to augment the research activity that grows from within the Trust itself, to develop SLaM staff as research-active clinicians, and provide all of our patients with the opportunity to take part in research.

Positive feedback from the CQC acknowledged the progress in implementing the R&D Strategy and the impact of research outcomes on clinical care (see Annex 1).

Embedding R&D as core business is multifaceted. Placing research as a core element of the Trust’s Changing Lives Strategy and ensuring that R&D leadership is part of Trust decision-making functions such as the Quality Centre, are key.

Many R&D activities have been developing over the last year so that the visibility of research within SLaM is increasing. We have a draft R&D Internal Communications Plan with new developments including R&D pages on Maud and Yammer, and R&D involvement in SLaM events such as the Staff Conference. We also had a stand for the International Clinical Trials Day to help raise awareness of the benefits of being involved in research.

Over the next few months, as the new Trust structures embed, we will be mapping research recruitment in clinical teams with the aim of using R&D funding to reward and incentivise R&D activity.

(ii) Strategic use of R&D funding
There has been a historic lack of clarity over how R&D income streams from NIHR are used within the Trust. If the R&D income streams to the Trust are not fully transparent with linkage to the R&D purposes for which they are awarded, there is a risk of financial penalty from the DHSC / NIHR. This could also result in reputational damage for SLaM as the UK’s leading research-active mental health Trust.

SLaM is currently undergoing an NIHR R&D Funding Review (effectively an audit), with the possibility of a review visit in December. Whilst the initial focus of the NIHR Review was on the BRC, follow-up questions and visits will focus on all NIHR funding, including Research Capability Funding (RCF).

Developing the necessary transparency around financial flows of all R&D income streams, including mapping funding to research activity within the new Trust structures, is a fundamental element of the R&D Strategy and there is further discussion needed to take this forward. This includes the need for the new Trust structures and Borough alliances to be developed with R&D financial arrangements clearly defined.

During 2018/19 there has been new strategic use of a small portion of R&D funding for clinical research sessions, a part-time research doctor and a part-time commercial trial doctor (MHOA). We are in the process of reviewing the value of this investment (please see below). We are also in the process of appointing an R&D Nurse Manager to support research delivery and development of nurses as R&D-active clinicians; this appointee will work closely with the newly-appointed Professor of Nursing at IoPPN.

(iii) Building SLaM’s research workforce
Recognition of R&D activity as a mainstream element within job planning is key – a medical staff job planning summary of how dedicated time for R&D activity might be included has been drafted.

As described in the previous section, individual research-interested clinicians (initially 8) have benefitted from R&D-funded sessions to help them develop as principal investigators for NIHR Portfolio studies and commercial studies; the part-time commercial trial doctor in MHOA has already engaged in several commercial studies and the part-time research doctor is supporting R&D activity in Psychosis. We are in the process of reviewing the value of this investment in order to plan for 2019/20.

(iv) Enhancing R&D income opportunities
The main drivers for increasing R&D income are recruitment into NIHR Portfolio Studies, NIHR research grant income and number of NIHR Senior Investigators (both generate further RCF), and commercial studies that generate surplus funding that benefits the Trust.
We are actively encouraging SLaM clinicians to act as principal investigators (P.I.s) on NIHR Portfolio Studies, especially those led from outside SLaM/IoPPN where SLaM can become a research sites, and also to be available to become P.I.s on commercial studies so that the Trust is receptive and ready when opportunities arise.

Our NIHR Portfolio recruitment activity has increased by 13% in the last year: 2016/17: 2087; 2017/17:2349). We are working increasingly closely with the Local Clinical Research Network to help drive up recruitment (by deploying CRN flexible working staff, supporting contingency funding bids and identifying studies looking for new sites). We have also increased the level of support provided by the R&D Office to assist researchers with uploading their recruitment data onto the data capture systems.

SLaM’s commercial activity is small, and we are seeking to enhance this with the development of the BRC-funded Centre of CNS Therapeutics. There has been a modest increase in commercial clinical trials opened (6 in 2017/18 compared with 5 in 2016/17) with recruitment increasing to 20 from 13 in these years, and we hope to develop this further. For example there are new opportunities being pursued within MHOA under Dag Aasland together with our commercial trials doctor.

NIHR Senior Investigators include some of the country’s foremost researchers, with 200 nationally (plus 127 emeritus). We have increased the number of NIHR Senior Investigators linked to SLaM, which contribute to driving RCF income, representing a substantial presence within the national context:

- 2017: 16 (10 plus 6 emeritus)
- 2018: 19 (12 plus 7 emeritus)

There has been increased effort within IoPPN to encourage individuals to apply to this scheme: 9 applications have been submitted in this year’s round (outcome expected March 2019).

(v) Recruitment of SLaM service users into research studies
This is summarised in section (iv) above and in the diagram at Annex 2 (SLaM R&D at a glance).

The efforts to increase the number of SLaM participants approached for Consent for Contact has resulted in an increase in those signing up from 1352 in 2016/17 to 1417 in 2017/18. The total number of SLaM service users who have said ‘yes’ to C4C since its inception is 15,380.

(vi) PPI involvement
We are continuing discussions with the Service User Research Enterprise (SURE) at IoPPN and with Gabrielle Richards in SLaM to develop a meaningful input from people with lived experience to the R&D piece. We are developing our thoughts in this area with a view to establishing service user ambassador roles across the Boroughs. We will also be looking at how to ensure carer inputs to R&D. These discussions will be taking place together with the BRC which already has a Service User Advisory Group (SUAG) which can be consulted on research design, scope and methodology.

(vii) Acknowledgement of SLaM on research publications and media communications
KCL staff are being asked to acknowledge SLaM if they hold an honorary contract with SLaM, giving SLaM as a secondary affiliation on their research publications. A small increase in SLaM research publications is evident looking at 2016 (435) and 2017 (457).

(viii) R&D Governance and management
All reporting requirements and deadlines for submissions to NIHR / DHSC have been met as have the regulatory and governance requirements.

Measuring research activity is challenging in terms of identifying which SLaM staff are involved in research. We will be developing our data collection and reporting systems to identify research activity at the clinical team level which will help address this.

We are also developing KPIs for R&D, which are currently with the SLaM senior management team for consideration.
Annex 1: CQC Report - Evidence appendix referring to SLaM R&D

The trust made the most of its close links with the Institute of Psychiatry, Psychology and Neuroscience (IoPPN) and the dean of the IoPPN was a member of the trust board. The two organisations worked together to establish excellence in research and the best possible treatment and care for people with mental illness.

The trust had a research and development strategy, which set out research priorities. The research and development committee met quarterly. The committee membership was multidisciplinary and included professional and clinical academic group leads. Minutes from the research and development committee meetings were shared with the trust board along with an annual report.

A risk assessment committee, with membership from SLaM and IoPPN, oversaw potential risks arising from research projects. Kings Health Partners (a partnership of the trust, Guys and St Thomas,’ King’s College and King’s College Hospital) oversaw the management of commercial studies and the risks involved.

The trust aimed to increase research capacity across all professional groups and promoted research as part of career development for staff. The trust was recruiting a nurse manager to develop the research capacity amongst nurses and setting key performance indicators for teams in terms of research. Small grants were made available to staff to conduct research projects at a ward/team level. Some of this money was used to support improved communications with staff and patients and raise awareness of research through the trust intranet.

The trust translated research findings into tangible benefits for patients. For example, a trial of a manual-based approach to the treatment of anorexia nervosa, resulted in this being recommended as the first line treatment by NICE in the eating disorder guidelines in 2017. In addition, the perinatal research team had developed an antenatal depression guided self-help intervention, which had been launched at perinatal network events. It was being used by many Improving Access to Psychological Therapies services across England.

Service users were encouraged to become involved in the research process through collaboration in the design, implementation and oversight of research. The trust had enrolled more than 15,000 patients and carers in ‘consent for contact’ or C4C, which enabled researchers to contact possible research participants directly to see whether they were willing to take part in projects. Services and teams advertised relevant research projects to service users and carers. The research and development committee was looking to increase the service user and carer voice through membership of the committee.
Annex 2

**South London and Maudsley NHS Foundation Trust**

**SLaM R&D 2018 - at a glance**

<table>
<thead>
<tr>
<th>#</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Top mental health Trust for number of research studies NIHR Portfolio studies 2017/18</td>
</tr>
<tr>
<td>2</td>
<td>Partnership with IoPPN at KCL Premier centre in Europe for mental health and neuroscience research</td>
</tr>
<tr>
<td>3</td>
<td>NIHR contract for the only Clinical Research Facility specialising in mental health and neuroscience</td>
</tr>
<tr>
<td>101</td>
<td>Open NIHR Portfolio studies 14% in 2017/18 compared with 89 in 2016/17</td>
</tr>
<tr>
<td>19</td>
<td>NIHR Senior Investigators</td>
</tr>
<tr>
<td>£22.5m</td>
<td>NIHR income 2017/18</td>
</tr>
<tr>
<td>2375</td>
<td>Participants recruited in NIHR Portfolio Research 13% in 2017/18 compared with 2097 in 2016/17</td>
</tr>
<tr>
<td>5</td>
<td>active NIHR Programme Grants for Applied Research</td>
</tr>
<tr>
<td>15,380</td>
<td>SLaM service users have said ‘YES’ to C4C Since Consent 4 Contact register began Sign up at <a href="mailto:c4c@slam.nhs.uk">c4c@slam.nhs.uk</a></td>
</tr>
<tr>
<td>457</td>
<td>SLaM research publications In 2017 compared with 439 in 2016 (↑)</td>
</tr>
<tr>
<td>20</td>
<td>Participants recruited into Commercial studies 54% in 2017/18 compared with 13 in 2016/17</td>
</tr>
</tbody>
</table>

**SLaM research making a Difference**

- Anorexia treatment recommended in NICE Eating Disorders Guideline 2017
- Interventions for domestic violence and abuse in mental health context informing clinician training
- Understanding perinatal mental disorders informing NHSE planning for perinatal psychiatry services
- Engaging in physical activity decreases the chance of depression
- Young people with serious mental illness benefit from community treatment
REPORT TO THE TRUST BOARD: PUBLIC
27 November 2018

Title | Finance Report as at 31 October 2018
---|---
Author | Andy Bell, Director of Finance
| Deborah Heron, Finance Business Partner
| Mark Nelson, Associate Director of Finance
Accountable Director | Gus Heafield, Chief Financial Officer

Purpose of the paper

The Finance Report provides an update on the financial position of the Trust as at 31st October 2018 (month 7). The summary financial statement and calculation of the Use of Resource rating from the NHSI Month 7 submission is attached to the report in Table 2.

Further to the discussions last month and subsequently the Trust has continued to forecast to NHSI a net deficit against our plan of £982k reflecting the gap on funding of the pay award in the monthly returns. We met with NHSI recently as part of our regular provider oversight cycle and were able to brief them on the flow plan and investment required as agreed by the Board last month and the risks to the delivery of the financial plan in 18/19. We have agreed a process for further work with them to describe the drivers to the underlying position, operational and flow pressures and the case for investment by commissioners as part of a two to three year financial plan.

We will provide an update and further detail for discussion and any appropriate options or decisions to the FPC when it meets in early December with a view to a more detailed analysis coming back to the Board in December 2018.

The Board is asked to approve the report including consideration of the pressures, risks and mitigations in place to meet the NHSI control total in the context of the work underway with NHSI described in outline above.

Executive Summary

The attached return shows an favourable YTD position of £0.2m and an adverse FOT variance of £1m (based on the shortfall in AfC funding). However, significant ongoing and emerging financial risks need to be mitigated and this is becoming an increasingly difficult gap to bridge. As a result, The Trust Board are keeping the financial outturn position under constant review. The Trust will continue to work with NHSI in the assessment of its position. Based on current assessment the risk to the forecast is circa £7.0m but it should be noted that this is not a worst-case scenario.

The current pressures on the SLaM financial position fall broadly into 3 categories:

1. **The need to ensure high quality and safe patient services**
   This, in part, requires responding to findings from the 2018/19 CQC inspection which were not in the original business plan. This has included making additional investment in estate as well as focusing SLaM management capacity on delivering the CQC’s requirements. The current estimate of additional cost is between £0.75m and £1.0m. This estimate could increase depending on the ongoing development of CQC compliance schemes which could increase the risk by £0.5m to £1.0m.

2. **The need to manage ongoing systemic inpatient bed pressure**
Demand for inpatient beds is exceeding the original plan across all boroughs and is evident in the increasingly high demand for Mental Health beds from ED presentations. This is driving significant additional cost in terms of the use of private beds and staffing our wards sufficiently with bank and agency medical and nursing staff. The current forecast spend on private beds is £2.6m but without mitigation this could increase to £4.9m based on a YTD run rate of 41 overspill beds per month.

In response to this system pressure the SELSTP and NHSI have been working with SLaM to develop a plan to help ease the capacity and flow issues in the system for the benefit of all provider Trust’s in the region. Whilst significant funding has been made available by the system it is likely that there will be a cost pressure of £1.5m (which includes a £0.8m contribution from winter funding income) for SLaM to deliver the full benefit of the proposed plan in 2018/19.

In addition to this immediate action there is also a system wide recognition that Adult Mental Health beds have been significantly under funded and this will require a more strategic solution in the longer term.

3. Cost Pressures Outside of SLaM’s direct control

A number of issues have emerged in year that would not have been reasonable to include in the Trust plan notably:

a. **Agenda for Change Pay Award Cost Pressure** – currently estimated at £1.0m unfunded cost.

b. **Reduction in R&D funding after the planning deadlines** - £0.5m reduction in RCF (infrastructure support funding) which is fully committed.

c. **New Models of Care funding challenges** – currently NHSE have not confirmed that they will fund Forensic beds in line with the agreed business case. In addition, NHSE have not yet agreed to fund the new CAMHS PICU service despite its request for the service and very good early outcomes reports. Currently, the Trust CIP plan assumes full funding which would yield a £2.0m saving for the Trust.

d. **Southwark Local Authority Placements** – The CCG and Local Authority no longer have a Section 75 agreement in place the local authority has indicated that it will fund to a level that is £1.5m short of the expected spend. The Trust is working with partners in Southwark to mitigate the risk but this is limited at this stage.

e. **Delay in Transfer of Kent CAMHS Services** – The Trust plan expected this service to transfer to NELFT in Q1. However, issues between NHSE London and NHSE South have meant this has been delayed at their request until March 2019 which has created an additional £0.5m cost pressure and increased projected medical agency usage significantly.

**Impact on Cost improvement**

There are 3 material impacts on CIP delivery based on the pressures highlighted above:

- **Private Bed Usage** - £2.4m CIP will not be achieved due to increased Demand pressure on inpatient beds. A significant overspend is expected if this is not reduced quickly in the immediate future.

- **SLP Savings** - £3.0m contribution from more efficient provision of Forensic and CAMHS services under New Models of Care is at risk if NHSE fail to meet requirements of agreed business cases. In addition, a range of other schemes including back office savings are being developed.

- **Borough Reconfiguration** – £1.0m the proposed efficiencies from the restructure have been paused in light of the focus on CQC and the significant challenges around inpatient demand and flow.

**Required Mitigations**

To achieve the reported delivery of the full year control total the following mitigations are required:

- Agenda for Change shortfall is centrally funded or Trust control total adjusted (£1.0m).
- NHSE fully fund the New Models of Care as per the agreed business cases (circa £2.0m)
- Local Authority Placements are fully funded by Southwark CCG and Local Authority as per previous Section 75 agreement (£1.6m).
- CQC Compliance work does not exceed existing forecast overspends (£0.8m).
- System pressure funding is made available to support short to medium term capacity and flow challenges (£1.4m).
- Additional Lock In and Replacement CIP schemes are identified (current assessment shows a potential yield of circa £3.0m).
- Additional mitigations are identified through not recurrent means (e.g. balance sheet items, disposals). It should be noted that the scope for additional disposals is limited in the current year.
- The introduction of flow and capacity plans ease the pressure on private bed usage across the remainder of the financial year.
- CQUIN is fully funded and there is no penalty to SLaM for unmet QIPP.
- There is an improvement in cost per case/variable activity as projected by local services.

Further detail on the above pressures and mitigations can be found below.

**Risks / issues for escalation**

| BAF Risk 1 | Workforce |
| BAF Risk 8 | Finance contracts |
| BAF Risk 9 | Estates |
| BAF Risk 11 | QI delivery |
| BAF Risk 12 | Finance – cost management |

1. **Explanation of YTD and FOT variances**

   - **Acute/PICU Overspill**

     Overall 41 overspill beds were used by the Trust in October, an increase on the previous 3 months and 38 beds above our original plan. However, this number has increased going into November (48 as at 13/11/18) and is at levels not seen since May 2017. The use of overspill and other non local CCG beds has resulted in a cost pressure, after application of risk shares, of £3m after 7 months. The Trust response to this is picked up in the Performance Report.

     The main drivers of this contract overperformance and hence resort to using beds outside the Trust continue to be Lambeth (ytd - 20% above contract), Southwark (ytd - 13% above contract) and Lewisham (ytd - 18% above contract). Lewisham in particular is experiencing unprecedented levels of contract overperformance as seen in the graph below –

![Lewisham CCG - Use of Acute/PICU Beds Since 1/4/17](image-url)
The use of all acute/PICU beds (internal and external) by LSL&C CCGs is shown in the tables below:

The second graph above indicates how far we are away from achieving our goal of 85% occupancy where the blue line indicates actual CCG bed usage versus the red and purple lines indicating 100% and 85% bed usage respectively. The table below highlights both the overperformance and associated CCG risk share payment attached to this. Further discussions are taking place with the local CCGs given the level of financial risk this presents to both parties.

<table>
<thead>
<tr>
<th>CCG</th>
<th>Plan Beds @ 100%</th>
<th>Actual Beds</th>
<th>Variance Beds</th>
<th>Variance %</th>
<th>Last Mth Variance</th>
<th>Risk Share Value £000</th>
</tr>
</thead>
<tbody>
<tr>
<td>Lambeth</td>
<td>95</td>
<td>114</td>
<td>18</td>
<td>19.4%</td>
<td>15</td>
<td>583</td>
</tr>
<tr>
<td>Southwark</td>
<td>87</td>
<td>99</td>
<td>11</td>
<td>13.1%</td>
<td>9</td>
<td>415</td>
</tr>
<tr>
<td>Lewisham</td>
<td>76</td>
<td>90</td>
<td>13</td>
<td>17.5%</td>
<td>11</td>
<td>469</td>
</tr>
<tr>
<td>Croydon</td>
<td>96</td>
<td>99</td>
<td>2</td>
<td>2.6%</td>
<td>2</td>
<td>50</td>
</tr>
<tr>
<td>NCA/Overseas</td>
<td>21</td>
<td>17</td>
<td>-5</td>
<td>-21.4%</td>
<td>-4</td>
<td>0</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>377</strong></td>
<td><strong>418</strong></td>
<td><strong>41</strong></td>
<td><strong>10.9%</strong></td>
<td><strong>32</strong></td>
<td><strong>1,517</strong></td>
</tr>
</tbody>
</table>

- **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 £1.8m above that ceiling at month 7 and at present rates of expenditure will be £3.9m 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 7 ytd the Trust had incurred an additional expense of c£1.9m above the cost of employing permanent SLaM staff, assuming a 20% agency premium.

Medical agency costs now represent nearly a third 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</th>
<th>Agency Usage</th>
<th>Estimated Cost Above Funding</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>£000</td>
<td>£000</td>
<td>£000</td>
</tr>
<tr>
<td>Lambeth</td>
<td>18,256</td>
<td>1,665</td>
<td>278</td>
</tr>
<tr>
<td>Southwark</td>
<td>21,730</td>
<td>1,525</td>
<td>254</td>
</tr>
<tr>
<td>Lewisham</td>
<td>15,602</td>
<td>1,405</td>
<td>234</td>
</tr>
<tr>
<td>Croydon</td>
<td>30,950</td>
<td>3,002</td>
<td>500</td>
</tr>
<tr>
<td>PMOA</td>
<td>21,123</td>
<td>623</td>
<td>104</td>
</tr>
<tr>
<td>CAMHS</td>
<td>21,117</td>
<td>1,324</td>
<td>221</td>
</tr>
<tr>
<td>Other</td>
<td>36,897</td>
<td>1,566</td>
<td>261</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>165,676</strong></td>
<td><strong>11,109</strong></td>
<td><strong>1,851</strong></td>
</tr>
</tbody>
</table>

- **Ward/Unit Nursing Costs**

At month 7 ward nursing costs overspent by £103k (£1.7m ytd). This now takes full account of the nurse bank pay award where arrears were paid in month 6. The impact of the pay award has been less than originally indicated by NHS Professionals (who run our nurse bank) but pay costs remain very high with overspends averaging more than they have done for at least the last 5 years. In addition it remains unclear whether the NHS pay award will be applied to nurse agency rates. No additional funding is being made available by the Department of Health. Although a 3% award would not increase ward/unit nursing costs materially (ward/units make relatively small use of agency staff), it would make a material difference to community nursing costs. The Trust is seeking clarity on this issue with the NHS London Procurement Partnership.
The main areas of concern remain with the Lambeth, Lewisham and Croydon adult wards which represent 79% of the total ward/unit nurse overspend. Included within this are Eden PICU (Lambeth), Johnson Unit PICU and Clare (Lewisham) and Fitzmary 1 (Croydon) which are all +20% above their funded nurse establishments.

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

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

- **Croydon (£0.4m adverse)** – income below target on Psychosis Unit (currently 71% occupancy following agreed bed closures) and NAU (reduction in beds/income due to continuing building works). In addition the ADHD clinics continue to only break even whereas last year they were overperforming against reduced income targets.

- **PMOA (£0.9m adverse)** – 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, neuro psychiatry and eating disorders inpatients & outpatients – continuing to underperform. In addition Chronic Fatigue and Affective Disorders are not currently meeting activity targets.

- **CAMHS (£1.5m adverse)** – the underperformance largely relates to outpatient services, in particular the Conduct Adoption and Fostering service and the Childrens Forensic Team where insufficient activity is taking place to fully meet costs. The latter service has now effectively ceased which should result in a reduction in costs. There is also 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 the second half of the year 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 but meeting its income target will rely upon the outcome of continuing contract negotiations with NHSE (both the tariff value and type of contract – block or cost and volume – are still under discussion.
### CAG Income Target

<table>
<thead>
<tr>
<th>CAG</th>
<th>Income Target At Month 7 £’000</th>
<th>Actual Invoiced At Month 7 £’000</th>
<th>Surplus/Deficit(-) At Month 7 £’000</th>
</tr>
</thead>
<tbody>
<tr>
<td>Lambeth</td>
<td>1,515</td>
<td>1,643</td>
<td>(128)</td>
</tr>
<tr>
<td>Southwark</td>
<td>922</td>
<td>956</td>
<td>(34)</td>
</tr>
<tr>
<td>Lewisham</td>
<td>354</td>
<td>390</td>
<td>(36)</td>
</tr>
<tr>
<td>Croydon</td>
<td>17,066</td>
<td>16,685</td>
<td>381</td>
</tr>
<tr>
<td>PMOA</td>
<td>10,916</td>
<td>10,021</td>
<td>895</td>
</tr>
<tr>
<td>CAMHS</td>
<td>14,215</td>
<td>12,728</td>
<td>1,488</td>
</tr>
<tr>
<td><strong>TOTAL</strong></td>
<td><strong>44,989</strong></td>
<td><strong>42,422</strong></td>
<td><strong>2,566</strong></td>
</tr>
</tbody>
</table>

Some of these shortfalls (33% 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 7 the LA element of placements has cost £2.2m 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 £1.5m. This situation is being taken up with the Council/CCG and whilst progress is being made, the funding gap still exists.

### Underlying position

- The current underlying position is under pressure mainly due to CIP slippage – notably in Overspill, Agency spend and SLP collaboration savings. Non-recurrent alternatives have been identified and these will be developed to see if they can be made recurrent. However, at this stage they are increasing the underlying position pressure.
- SLaM remains committed to eliminating its underlying position over the next 3 years and this is a feature of the Trust’s LTFM.

### Run rates

- See above

### High Risk CIPs

<table>
<thead>
<tr>
<th>Name</th>
<th>Risk Level</th>
<th>YTD Plan £000s</th>
<th>YTD Actual £000s</th>
<th>YTD VAR £000s</th>
<th>FY Plan £000s</th>
<th>FY Forecast £000s</th>
<th>FY VAR £000s</th>
<th>Narrative</th>
</tr>
</thead>
<tbody>
<tr>
<td>Overspill Reduction</td>
<td>High</td>
<td>1,407</td>
<td>-280</td>
<td>-1,687</td>
<td>2,403</td>
<td>0</td>
<td>-2,403</td>
<td>Overspill remains High Risk due to ongoing bed pressures in SE</td>
</tr>
<tr>
<td>Task Description</td>
<td>Risk Level</td>
<td>High</td>
<td>Medium</td>
<td>Low</td>
<td>Savings Realised</td>
<td>Notes</td>
<td></td>
<td></td>
</tr>
<tr>
<td>------------------------------------------</td>
<td>------------</td>
<td>-------</td>
<td>--------</td>
<td>-------</td>
<td>-----------------</td>
<td>----------------------------------------------------------------------</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Direct engagement of staff</td>
<td>High</td>
<td>49</td>
<td>0</td>
<td>-49</td>
<td>80</td>
<td>-80 Scheme delayed</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Estates Reduction 1</td>
<td>High</td>
<td>60</td>
<td>235</td>
<td>175</td>
<td>358</td>
<td>327 -31 This is still expected to largely deliver but pressure on estates due to CQC related programmes means this remains a high risk.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Lambeth &amp; Lew PICUs</td>
<td>High</td>
<td>58</td>
<td>4</td>
<td>-54</td>
<td>156</td>
<td>29 -127 This remains high risk due to demand pressures on beds</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Borough Restructure Target - 2nd Tranche</td>
<td>High</td>
<td>50</td>
<td>50</td>
<td>0</td>
<td>300</td>
<td>300 0 Savings have been identified but on hold following focus on CQC issues and inpatient pressures</td>
<td></td>
<td></td>
</tr>
<tr>
<td>SLP Collaboration</td>
<td>High</td>
<td>83</td>
<td>83</td>
<td>0</td>
<td>500</td>
<td>500 0 Credible plans to deliver this level of savings through SLP have been identified but are dependant on NHSE honouring previous agreements around settlements on CAMHS tier 4 and Forensics</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Promoting Recovery Teams</td>
<td>High</td>
<td>81</td>
<td>81</td>
<td>0</td>
<td>486</td>
<td>486 0 Was expected to deliver but will remain high risk until Borough reconfigurations are finalised</td>
<td></td>
<td></td>
</tr>
<tr>
<td>CPC Outpatients</td>
<td>High</td>
<td>112</td>
<td>8</td>
<td>-104</td>
<td>201</td>
<td>45 -156 Activity driven – remains high risk</td>
<td></td>
<td></td>
</tr>
<tr>
<td>CAMHS inpatient income</td>
<td>High</td>
<td>112</td>
<td>0</td>
<td>-112</td>
<td>191</td>
<td>0 -191 Delay in converting beds to HDU</td>
<td></td>
<td></td>
</tr>
<tr>
<td>CAMHS Southwark Estates savings tied into service redesign</td>
<td>High</td>
<td>42</td>
<td>65</td>
<td>23</td>
<td>76</td>
<td>76 0 This relates to the exit of a Trust site that is off track - alternative schemes are being identified</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Nursing Management Unidentified CIP 18/19</td>
<td>High</td>
<td>21</td>
<td>0</td>
<td>-21</td>
<td>38</td>
<td>0 -38 Nursing management budgets are underspending but this CIP is yet to be finalised.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Site Manager Post redundant</td>
<td>High</td>
<td>42</td>
<td>0</td>
<td>-42</td>
<td>68</td>
<td>0 -68 Post removed but non rec redundancy payment offsetting saving</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Agency Spend</td>
<td>High</td>
<td>224</td>
<td>224</td>
<td>-0</td>
<td>500</td>
<td>500 0 Pressure on inpatient beds and ongoing recruitment challenges means agency is running above the agreed ceiling. This is expected to improve through the year but will be dependent on SlaMs exit from Kent CAMHS which is under review with NHSI.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Total</td>
<td></td>
<td>2,341</td>
<td>470</td>
<td>-1,871</td>
<td>5,357</td>
<td>2,263 -3,094</td>
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<td></td>
</tr>
</tbody>
</table>

5. Use of Contingencies & Risk Reserves

- Due to the pressures detailed in the YTD and Forecast position all contingencies and reserves are fully committed.
- In its plan the Trust had an initial £1.8m general reserve which has been utilised to support in year pressures (e.g. Overspill and Ward costs) and Service developments (e.g. CQC related support schemes)

6. Cash & Working Capital Position
• BPPC, Debtor and Creditor Positions and Days remain accurate and are subject to robust processes that are regularly reviewed and audited.
• The Trust continues to have a robust cash position which will remain across the financial year.

7. Balance Sheet

• No issues of note at this point in the year other than timing.
• Capex YTD M07 is £5.4m behind plan due to slippage including:
  o £0.9m Norbury Ward
  o £0.7m ICT projects
  o £0.5m AL3 Ward Refurbishment
  o £0.5m CAMHS LD
  o £0.4m Clinical Room Environment
  o £0.4m Estates Backlog maintenance schemes
  o £0.4m Gracefield Gardens refurb
  o £0.4m New Build NAU
  o £0.3m New build CYP

8. Revenue Support Drawdown

• The Trust does not expect to draw down any revenue support in 2018/19.

9. Schedule of risks and opportunities against FOT

• Acute overspill averaged 41 beds in the month – a significant increase on September (29) – but since the 2nd half of September the position has been deteriorating (48 as at 13/11/18). This number excludes local CCG patients overspilling 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 £3m 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. Current ytd positions are as follows: Lambeth 20% above contract, Lewisham 18% over contract, Southwark 13% over contract, Croydon 3% over contract. The Trust is in discussion with NHSI, the STP and SLP regarding the demand pressures being experienced and what mitigations can be put in place including the use of any winter pressure funding.

• Ward nursing costs have remained high with associated overspends at their highest levels since 2012/13. 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 where our nurse bank staff are paid on an increment point that attracts a higher level of pay award 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.

• 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 £2.4m of activity when activity is forecast to cost £3.9m. 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 7 months is £1.8m 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 £1.4m higher than at this point last year and on current run rates will
exceed the new ceiling by £3.9m at year end. This would also mean exceeding the NHSI ceiling by more than 25% triggering an increase on the agency element of our NHSI use of resources risk rating (from a 2 to a 3). Medical agency costs remain disproportionately high (a third of total agency costs) 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 £2.5m at month 7. Corresponding pay underspends will mitigate 33% of this variance but a number of services are required to improve their performance over the remaining 5 months.

- The month 6 assessment of the impact of the AfC pay award decreased from £5.0m to £4.6m, and the unfunded amount from £1.4m to £1.0m. This decrease results from an analysis of paid arrears for bank staff in month 6 extrapolated for the year plus a small increase (£100k) in the funding now being provided by the Department of Health. It seems unlikely that any further funding will be made available and this £1m cost pressure will need to be taken account of in our forecast position.

Based on the above the Trust has identified financial risks though totalling c£8m by year end (excluding the Southwark LA placements issue described above). These can be mitigated as described on page 2 above

10. Income Assumptions & Commissioner Challenges

- All CCG core contracts have been agreed and cross referenced at STP level.
- Risk shares around bed days are being calculated based on agreed contract terms.
- There are ongoing negotiations around deployment of Mental Health Investment Standard (MHIS) funding through agreed SDIPs with CCGs. These discussions are moving forward positively.
- Any emerging commissioner issues are dealt with at regular core contract meetings with all key CCGs.
- Discussions with NHSE around funding settlements for SLP related schemes (Forensics and CAMHS tier 4) are ongoing.
- The Trust has seen a £0.5m reduction in its RCF R&D funding from the DH which it was not notified of until May 2018.
- Southwark CCG and Local authority do not currently have an agreed section 75 which means that a funding risk around complex placements has emerged for SLaM. The local authority has stated there intention to limit funding to £2.4m which is projected to be £1.5m below the funding required. This remains a risk to the current forecast which will be reassessed over the next few months.

Glossary

<table>
<thead>
<tr>
<th>AMH</th>
<th>Adult Mental Health – used in this report to cover a programme of investment in community schemes that aim to reduce the usage of acute/triage beds in the Trust</th>
</tr>
</thead>
<tbody>
<tr>
<td>CCG</td>
<td>Clinical Commissioning Group – an NHS body responsible for the planning and commissioning of health services for their local area</td>
</tr>
<tr>
<td>CIPs</td>
<td>Cost Improvement Programme</td>
</tr>
<tr>
<td>CPC/C&amp;V</td>
<td>Cost per Case and Cost and Volume income varies depending upon the amount of clinical activity being undertaken</td>
</tr>
<tr>
<td>EBITDA</td>
<td>Earnings before interest, tax, depreciation and amortisation is an accounting</td>
</tr>
<tr>
<td>Acronym</td>
<td>Definition</td>
</tr>
<tr>
<td>---------</td>
<td>------------</td>
</tr>
<tr>
<td>ICT</td>
<td>Information and Communications Technology</td>
</tr>
<tr>
<td>NCA</td>
<td>Non Contracted Activity - a patient treated by SLaM where no contract exists between the Trust and the Commissioner (e.g. a Lewisham resident who has a Bromley GP will not be charged against the Lewisham contract but will be invoiced as an NCA to Bromley CCG)</td>
</tr>
<tr>
<td>NHSI</td>
<td>NHS Improvement – the new regulatory body overseeing all NHS providers as well as independent providers that provide NHS funded care</td>
</tr>
<tr>
<td>OBD</td>
<td>Occupied Bed Day – is a unit of currency used to measure the use made of a bed (e.g. 1 obd = 1 bed occupied for 1 day by a patient)</td>
</tr>
<tr>
<td>O/P</td>
<td>Outpatient</td>
</tr>
<tr>
<td>PICU</td>
<td>Psychiatric Intensive Care Unit - provide mental health care and treatment for people whose acute distress, absconding risk and suicidal or challenging behaviour needs a secure environment beyond that which can normally be provided on an open psychiatric ward</td>
</tr>
<tr>
<td>PoS</td>
<td>Place of Safety – under section 136 of the Mental Health Act, the police have the power to take an apparently mentally disordered person who is in a public place and is apparently a danger to himself or to other people, to a &quot;place of safety&quot; where they may be assessed by a doctor</td>
</tr>
<tr>
<td>QIPP</td>
<td>The Quality, Innovation, Productivity and Prevention programme is a series of schemes required by the CCGs and developed with SLaM to help reduce the cost of services to the CCG</td>
</tr>
<tr>
<td>STF</td>
<td>Sustainability &amp; Transformation Fund that is intended to support providers to move to a sustainable financial footing</td>
</tr>
<tr>
<td>STP</td>
<td>Sustainability and Transformation Partnership. These are 44 areas covering all of England, where local NHS organisations and councils have drawn up proposals to improve health and care in the areas they serve.</td>
</tr>
<tr>
<td>Triage</td>
<td>Triage ward – used to admit patients for a short period of time where their needs are assessed before being either discharged to the care of community teams or transferred to an acute ward</td>
</tr>
<tr>
<td>WTE</td>
<td>Whole Time Equivalent – is a concept used to convert the hours worked by several part-time employees into the hours worked by full-time employees e.g. 1 wte = 1 full time employee</td>
</tr>
<tr>
<td>YTD</td>
<td>Year To Date</td>
</tr>
</tbody>
</table>
**Key Financial Drivers**

- **Performance of CIP - £1.7m below the NHSI plan - 20% c target**
- Ward Costs - £1.7m overspent
- Acute Overspill - £4.5m overspent (excluding impact of risk shares)
- Complex/Non Secure Placements - £0.3m underspent (excluding impact of risk shares)
- Cost per Case/Cost & Volume - £2.6m ytd (target £9.00 ytd cost) offsetting pay costs
- % variance

**Commentary**

1. At month 7 ytd the Trust made a surplus of £1m, a favourable variance of £2.2m against the NHSI surplus control target.
2. Acute overspill averaged 41 beds in the month – an increase from an average of 29 beds in Q2. This number excludes local CCG patients overspilling to Trust beds that were planned to be funded by NCA activity (non contracted activity – primarily overseas and cross boundary placements). The net financial impact of overspill and loss of NCA income is £3m ytd after the impact of risk shares. Clearly this is a major risk to financial plan if it continues at levels well above the 3 beds included in the plan. Current ytd positions of CCGs against contract are: Lambeth 20%, Lewisham 18%, Southwark 4%, Croydon 3%.
3. Ward nursing costs remain high particularly the Lambeth, Lewisham and Croydon adult wards which represent 74% of the total. Although these costs 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 where our nurse bank staff are paid on an increment point that attracts a higher level of pay award than similar staff on the same band but at a different increment point. This fact has not been recognised in the pay award uplift from the Department of Health.
4. As at month 7, the Trust had generated CIP savings of £5.9m. The current adverse variance from the CIP plan of £1.7m largely driven by our failure to meet overspill targets as indicated above. Further risks are likely to emerge in the second half of the year if NHSE fail to meet the requirements of agreed New Models of Care business cases and proposed efficiencies from the borough restrictions are passed in light of the Trusts on CCG and the significant challenges around recurrent demand and flow. The Trust is largely meeting its NHSI QIP targets although it is not keeping to its baseline acuity bed positions.
5. Complex placements are reporting a balanced position. However there remains a key risk in Southwark where the Local Authority are not longer a Section 75 arrangement with the CCG. This means the Trust is more exposed on securing the funding required to meet those placement costs.
6. The Trust had planned for a reduction in agency costs, in line with the new NHSI ceiling. However agency usage over the first 7 months is £1.8m 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 £1.4m higher than at this point last year and on current run rates will exceed the new ceiling by £2.8m at year end. Medical Agency costs are disproportionately high and agency usage is highest in the adult inpatient services.
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8. Although established pay budgets have been uplifted in line with the award, sufficient funding has not been provided by the DoH to cover this increase in costs. We have estimated a shortfall of £1.3m.
9. The Trust is currently rated by NHSI as a 2 against use of resources (where 1 is best out of a 1-4 range – see Table 2). This rating relates to the actual performance of the Trust only. We are forecasted to remain at a score of 2 provided the Plan is met. However the score on use of agency staff is likely to deteriorate (currently a 3) as the Trust continues to employ considerably more agency staff than allowed in its NHSI target.

**Profit**

- EPL £17.8m

**Capital speed against plan**

- Critical Path Analysis
- £15.6m
- £13.8m

**Key Financial Drivers**

- Forecast 2016/17 less than 2 out of 3 criteria
- Better payment practice code (post 66/55 by value)
- Better bank balance

**Key Financial Drivers**

- Performance CIP - £2.7m below the NHSI Plan – 20% c target
- Ward Costs - £1.7m overspent
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Position continues to be driven by use of acute beds above contract (£1m over in 3rd quarter). Wards are overspending particularly Eden PCU (£175k) and Luther King (£83k). Delays QPR delivery on SHARP. Home Treatment Team pay overspend continues (£272k over). Other overspends £218,400. Adverse acute overspill variance of £687k incl risk share, John Dickson and AL wards are overspending (£223,100 YTD / AL E89Y Add). Additional CCG income re placements this year BUT concern over the Local Authority element where the LA have stated they are reducing their funding of an already overspending budget (current assumption is line but could be £1.9m over at end year).

Southwark

31. Lewisham

34. Croydon

55. RNA

36. Child & Adolescent Service

70. Corporate Other

71. Contingency - planned

72. Other reserves/provisions

Position driven by a combination of ward expenditure and overspill costs. All 5 wards are overspending (in total £218,400). Adverse acute variance of £687k incl risk share - the significant deterioration seen in mth 5 has come down slightly (now 26% above contract in the month). £287k overspend on A&L (pay costs).

General underspends in older adult services helped by good control of ward/unit budgets. Large income related issues on adult services with activity below target mitigated by pay underspends.

Low hardwired occupancy but high costs (med agency) set to continue with transfer of service delayed (£375k YTD). £180k overspend on new PICU due to delays.

Includes various cost pressures in Estates (maint teams, hotel services) HR (training income, cost of payroll transfer & apprenticeship scheme), Medical (junior doctors), Nursing (legal fees - inquests) & R&D (0.5m reduction in RCF funding).

Position driven by use of acute beds above contract (£1m over in 3rd quarter). Wards are overspending particularly Eden PCU (£175k) and Luther King (£83k). Delays QPR delivery on SHARP. Home Treatment Team pay overspend continues (£272k over). Other overspends £218,400. Adverse acute overspill variance of £687k incl risk share, John Dickson and AL wards are overspending (£223,100 YTD / AL E89Y Add). Additional CCG income re placements this year BUT concern over the Local Authority element where the LA have stated they are reducing their funding of an already overspending budget (current assumption is line but could be £1.9m over at end year).

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## Table 2

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

### Key data

<table>
<thead>
<tr>
<th>PLAN YTD</th>
<th>ACT YTD</th>
<th>VAR YTD</th>
<th>PLAN CY</th>
<th>FOT CY</th>
<th>VAR CY</th>
</tr>
</thead>
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<tr>
<td>£’000</td>
<td>£’000</td>
<td>£’000</td>
<td>£’000</td>
<td>£’000</td>
<td>£’000</td>
</tr>
<tr>
<td>31/10/2018</td>
<td>31/10/2018</td>
<td>31/10/2018</td>
<td>31/03/2019</td>
<td>31/03/2019</td>
<td>31/03/2019</td>
</tr>
</tbody>
</table>

### Performance against control total

- **Surplus/(deficit) before impairments and transfers**: 788, 1,011, 223
- **Adjusted financial performance surplus/(deficit) including PSF**: 1,096, 1,319, 223
- **Control total**: 1,068, 1,068, 0
- **Performance against control total excluding PSF**: 28, 251, 223

### Performance against control total excluding PSF

- **Adjusted financial performance surplus/(deficit) including PSF**: 1,096, 1,319, 223
- **Less provider sustainability fund (PSF)**: (1,431), (1,431), 0
- **Adjusted financial performance surplus/(deficit) excluding PSF**: (335), (112), 223
- **Performance against control total excluding PSF**: 28, 251, 223

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

- **Including PSF**: 0.49%, 0.58%, 0.09%
- **Excluding PSF**: (0.15%), (0.05%), 0.10%

### Capital

- **Gross capital expenditure**: 11,387, 5,980, 5,407
- **Disposals / other deductions**: (10,100), (10,100), 0
- **Charge after additions/deductions**: 1,287, (4,120), 5,407
- **Total CDEL**: 1,287, (4,120), 5,407

### Cash

- **Cash and cash equivalents at period end**: 66,521, 75,809, 9,288
- **DHSC capital financing**: 732, 0, (732)
- **DHSC interim revenue financing**: 0

### Agency and contract

- **Total agency costs excluding outsourced bank**: 9,287, 11,110, (1,823)
- **Updated agency ceiling**: 9,287, 9,287, 0

### Turnover

- **Total operating income**: 223,856, 228,928, 5,072
- **Less capital donations/grants income impact**: 0
- **Remove impact of prior year PSF post accounts reallocation**: 0
- **Total turnover**: 223,856, 228,928, 5,072

### Use of resources risk rating summary

#### Capital service cover rating

<table>
<thead>
<tr>
<th>PLAN YTD</th>
<th>ACT YTD</th>
<th>VAR YTD</th>
<th>PLAN YTD</th>
<th>ACT YTD</th>
</tr>
</thead>
<tbody>
<tr>
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<td>31/10/2018</td>
<td>31/10/2018</td>
<td>31/03/2019</td>
<td>31/03/2019</td>
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<tr>
<td>3</td>
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### Liquidity rating

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### I&E margin rating

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<th>VAR YTD</th>
<th>PLAN YTD</th>
<th>ACT YTD</th>
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<td>31/10/2018</td>
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### I&E margin: distance from financial plan

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<th>VAR YTD</th>
<th>PLAN YTD</th>
<th>ACT YTD</th>
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### Updated agency rating

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<tr>
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<th>VAR YTD</th>
<th>PLAN YTD</th>
<th>ACT YTD</th>
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<td>31/10/2018</td>
<td>31/03/2019</td>
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</table>

### Risk rating after overrides

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<thead>
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<th>VAR YTD</th>
<th>PLAN YTD</th>
<th>ACT YTD</th>
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</table>
Table 3 Summary CIP Performance

### TRUST CIP POSITION

<table>
<thead>
<tr>
<th>Financial Position M7</th>
<th>RAG Ratings &amp; Risks</th>
<th>Income/Cost Type</th>
<th>FY Plan 18/19</th>
<th>FY Forecast 18/19</th>
<th>FY Variance 18/19</th>
</tr>
</thead>
<tbody>
<tr>
<td>FYP £</td>
<td>Total CIPs 70</td>
<td>Pay</td>
<td>8,726</td>
<td>11,096</td>
<td>2,370</td>
</tr>
<tr>
<td>CYP £</td>
<td>No of CYP Forecast</td>
<td>Non Pay</td>
<td>6,428</td>
<td>4,025</td>
<td>(2,403)</td>
</tr>
<tr>
<td>Forecast Outturn</td>
<td>% Plan</td>
<td>Income</td>
<td>1,247</td>
<td>1,280</td>
<td>33</td>
</tr>
<tr>
<td>YTD Plan</td>
<td>Total</td>
<td>Total</td>
<td>16,401</td>
<td>16,401</td>
<td>(0)</td>
</tr>
<tr>
<td>YTD Actuals</td>
<td>Schemes £'000s</td>
<td>Recurrent</td>
<td>15,021</td>
<td>12,814</td>
<td>(2,207)</td>
</tr>
<tr>
<td></td>
<td>Medium</td>
<td>Non Recurrent</td>
<td>1,380</td>
<td>3,587</td>
<td>2,207</td>
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<tr>
<td></td>
<td>High</td>
<td></td>
<td>5,247</td>
<td>5,287</td>
<td>40</td>
</tr>
<tr>
<td>YTD Variance</td>
<td>Unidentified</td>
<td></td>
<td>(1,081)</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>YTD Achieved %</td>
<td>76%</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

### Summary of Progress

The position at Month 7 is slightly behind the in month target of £1m by (100k) and £1.6m behind the YTD target of £7.6m. Year to date 78% of the CIPS has been achieved.

The primary driver behind the YTD position is acute overspill which accounts for all of £1.6m YTD underachievement.

The full year forecast is expected to deliver to the plan £16.4m which includes non recurrent values of £3.9m in relation to lock ins, which offset the deterioration of the overspill position which is now not expected to contribute.

There are some potential risk areas within the forecast which requires consideration:

a) within the forecast there is £2.9m of schemes which are Red Rated- this includes savings relating to the restructure, Estates, SLP collaboration and Overspill

b) Notable areas where there are potential risks to the projected forecast includes:
   - Lewisham - Lewisham Triage and PICU (£107k)
   - Lewisham - PICU, OASIS and CPC - Self Harm (£162k)
   - CAMHS - N&S Inpatient SIDS Income (£191k)
   - PM&EM - CPC - Neuropsychiatry (£113k)

The key movements contributing to the forecast variance are:

**Significant movements in M7**

- Overspill on beds: -2.40m
- Trustwide - the lock in position is expected to be more favourable than planned: 2.30m
- Medical - ahead of target on training review: 0.13m
- Nursing & Clinical Governance - slightly ahead of target on staffing reviews in Health and Safety and Chaplaincy: 0.03m
- Total: 0.0m

**Summary**

- Boroughs: -2.40m
- Trustwide: 2.30m
- Corporate: 0.20m
- Total: 0.0m
EXECUTIVE SUMMARY

The dashboard and summary paper show estates performance in key areas in the year to date up to M06 FY18/19:

1. The cumulative estates & capital project spend to date at M06 FY18/19 (excluding IT, DBH & CYP) is 51.96% of plan with a year-end projected variance of £12,174k or 59.22% of plan. However as a measure of performance this doesn’t reflect the overall position for the capital programme.

2. Key drivers of this variance in M06 relate to the items below. When these are taken into account a true measure of variance forecast for the year is approximately 40%:
   - lack of suitable decant space necessary to enable ward refurbishments. - £2,000k
   - no scheme proposed for CAMHS LD (NHSE PDC) - £2,700k
   - availability of LIFT co resources for Gracefield Gardens refurbishment - £700k
   - delayed programme for Douglas Bennet House - £800k

3. The operating budget for the Directorate shows an in-month variance of £254k, 1.7% over budget with a year-end forecast of £29,832k – a variance of £20k at 0.07% over budget.

4. Reactive maintenance performance KPI’s continue to be impacted by incorrect job coding for Priority 1 calls. A deep dive review of the data has been undertaken for M03 to M06 and team has confirmed that no genuine Priority 1 calls were left unresolved outside of the agreed KPI’s. The team are further interrogating the information and a summary of the problems and how we are addressing these will be given in the next Estates report.

5. Overall compliance performance continues to be strong, with mitigations in place for all areas where there are minor derogations.

6. Going forward we will provide key performance indicators for the ISS Contract covering catering and domestic services. Whilst these were not areas that were picked out as needing urgent...
attention during the CQC visit there are a number of processes that we need to revisit by ISS aswell as our operational and nursing staff and we are working with the DoN and COO to implement an improvement plan.

The paper provides a further update to the key risks for FY 18/19, which continue to include the risk of variance in delivery of the capital plan, achieving substantial visibility of the estate where we are tenants and improving the estates/operations interface. Recruitment continues across the Capital team with two new in-house Project Managers now on board and interviews for a Head of Capital due to take place in November 2018.

The paper also reports on the Douglas Bennett House and Children and Young Persons projects, updating the commercial and programme position as of M06 FY18/19 following substantial work being undertaken since the July 2018 Trust Board. Regarding CYP a key point to note, is that SLAM will need agreement with KCL on accommodation and financial contribution (Capital and Revenue) before appointment of a supply chain can be made.

**Risks / issues for escalation**

This report relates to the following Board Assurance Framework (BAF) risks, further risk and escalation items are noted below:

- **BAF Risk 1 - Workforce**
- **BAF Risk 9 – Estates**
- **BAF Risk 11 QI delivery**
- **BAF Risk 12 Finance – cost management**

**ISS Contract:** The Trust continues to work with ISS and monitor them closely in line with the agreements made within the bid. There are regular weekly and monthly meetings between the Trust and ISS aswell as closer monitoring processes that provide better visibility of catering and domestic services to ward, clinical and performance management staff.

**Committees where this item has been considered**

<table>
<thead>
<tr>
<th>Date</th>
<th>Committee / Meeting</th>
</tr>
</thead>
<tbody>
<tr>
<td>26th November 2018</td>
<td>Finance and Performance Committee</td>
</tr>
</tbody>
</table>
Introduction & Context

This paper provides expanded commentary to the November 2018 CEF Dashboard Performance report to provide detail and further narrative on the departments performance to M06.

CEF Key Directorate Risks in FY18/19

Following the initial presentation at the April 2018 Finance & Performance Committee, updates to the mitigation proposals have been provided for all CEF Directorate risks.

<table>
<thead>
<tr>
<th>Key Risk</th>
<th>Mitigation Proposal</th>
</tr>
</thead>
<tbody>
<tr>
<td>Visibility on the condition of the whole Estate, particularly where the Trust are a tenant to a third-party landlord.</td>
<td><strong>April 2018:</strong> Follow up on gap analysis exercise to identify key third party landlords with outstanding compliance information. <strong>June 2018:</strong> All landlords have been written to including full request of any outstanding information, no responses to date. Requires escalation. <strong>November 2018:</strong> Follow up letters have been sent to all parties. A review of responses will be undertaken in month and escalated where appropriate.</td>
</tr>
<tr>
<td>Independent assurance of statutory Estate compliance.</td>
<td><strong>April 2018:</strong> Engage a third party to review the in-house team assurance processes and data. <strong>June 2018:</strong> Gleeds have been appointed to undertake this work to be progressed in July 2018. <strong>November 2018:</strong> This has been completed.</td>
</tr>
<tr>
<td>Delivery of FY18/19 Capital &amp; Revenue Plans given divergence in FY17/18.</td>
<td><strong>April 2018:</strong> Continued implementation of TIAA and GSTT audit recommendations in addition to prevailing turnaround activities and resource stabilisation. <strong>June 2018:</strong> Additional interim delivery and management resource has been established whilst recruitment of full time roles is completed. <strong>November 2018:</strong> Two new internal Trust Project Managers have been recruited and the Head of Capital role is to be interviewed in November 2018.</td>
</tr>
<tr>
<td>Delivery of FY18/19 Disposal Programme.</td>
<td><strong>April 2018:</strong> Adherence to Disposal audit recommendations and revision of internal processes and gateway checks. <strong>June 2018:</strong> Actions underway, linked to the update of the Community Estate Strategy. Live in Guardians engaged to protect vacant properties. <strong>November 2018:</strong> All community estates workshops with operational and clinical staff have been undertaken and the community strategy is being developed for submission to the Executive Team.</td>
</tr>
<tr>
<td>Category</td>
<td>April 2018</td>
</tr>
<tr>
<td>-----------------------------------------------</td>
<td>------------</td>
</tr>
<tr>
<td>Managing variation (on specification and</td>
<td>April 2018: Implementation of revised processes and procedures and improved communication with Service staff supported by robust sign off mechanics supported by the Executive team. June 2018: Continued implementation and additional management resource supporting the development of new schemes. Lessons Learnt workshops with all stakeholders being arranged for legacy schemes. November 2018: A Lessons Learnt workshop has been held for the Bridge House scheme with the key findings now being implemented across the programme.</td>
</tr>
<tr>
<td>programme) for key quality and refurbishment</td>
<td></td>
</tr>
<tr>
<td>schemes.</td>
<td></td>
</tr>
<tr>
<td>Morale and retention.</td>
<td>April 2018: Close out of staff consultation processes started in Q3 FY17/18. June 2018: Estates consultation complete, Portering has been delayed but aiming to close out in August 2018 with new rosters starting in September 2018. November 2018: Work is ongoing regarding specific areas of concern and staff are being encouraged to complete the staff survey. The results from this work will feed into a wider plan to address staff issues and concerns.</td>
</tr>
<tr>
<td>Delivery of CYP Project.</td>
<td>April 2018: Draft strategic case being prepared for June 2018, progress to be reported against this going forward. June 2018: SOC has now been completed, initial financial modelling across the lifecycle of the development shows an I&amp;E and cashflow challenge, Programme Board have agreed a further 30 days’ work to undertake further financial due diligence in response to this. November 2018: We will need agreement with KCL on accommodation and financial contribution (Capital and Revenue) before appointment of a supply chain is made.</td>
</tr>
<tr>
<td>Progress on Anti-Ligature Programme.</td>
<td>April 2018: Additional resource secured in April 2018 to drive the programme, initial items identified for immediate action to be taken to CRG in April 2018. June 2018: Programme contractor now appointed with pre-start meetings in July 2018. November 2018: Works now on site and progressing, completion expected within FY 18/19.</td>
</tr>
</tbody>
</table>
Children & Young Persons (CYP):

- The CYP programme has completed the SOC stage and gained Trust Board approval (at the September Board) to continue
- Currently due diligence work is being undertaken with regard to the procurement and cost of securing a supply chain
- Advice having been sought from Capsticks, AECOM, Gardiner and Theobald and the DHSC Procure 21 Framework team and is being reviewed
- Before appointment of a supply chain it is not possible to accurately define the programme plan or cash flow model for this type of complex scheme although it is likely that expenditure on the next stage of development will not exceed £2.7m over a 12 month period
- We will need agreement with KCL on accommodation and financial contribution (Capital and Revenue) before appointment of a supply chain is made

Douglas Bennett House (DBH):

- The Trust Board in September agreed that the DBH scheme can progress through to Stage 3 and preparations are being made for the contract to support this
- Discussions are ongoing with NHSI to determine the process we are required to follow for the business cases and what ‘assurance’ will involve
- Part of developing this contract is the agreement of the programme plan and cash flow model, although these are not yet complete
- The spend to date in FY18/19 at M06 on this scheme is £795k

Chart 2: Strategic Capital Schemes Update: Cost & Cashflow at M06 FY18/19

Following the changes noted under Chart 1 there remain several variables to manage and actions to complete before a rebased cash flow projection can be provided:

1. Negotiation of programme approach with NHSI
2. Procurement of a principle supply chain partner for CYP
3. Rescheduling the DBH OBC into an FBC
4. Development of the FBC schedule for CYP
Performance Overview:

- M06 cumulative position is £2,871k, a variance of £2,349k or 51.96% of the plan.
- Forecast spend to year end is £8,383k, a variance of £12,174k or 59.22% of the plan.

Variance driven by:

- Suitable decant space is not currently available across the Trust and greater South London Partnership estate. Therefore, the unallocated ward refurbishment capital (£2,000k) and AL3 ward refurbishment (£850k) will not be deliverable in FY18/19.
- In line with SFIs the Trust has requested that all future window replacements schemes are now competitively tendered, pushing £2,600k of spend into FY19/20. This impacts Lambeth Windows, Gresham & Fitzmary and Tyson House.
- Gracefield Gardens spend (£700k) has been delayed to FY19/20 due to ongoing development discussions with the provider.
- In month variance has been driven by on-site delays to several schemes, however the relevant spend will be made with FY18/19.

Departmental Improvement & Resourcing:

- The Trust has now appointed two new in-house Project Managers and are interviewing for a new Head of Capital Projects with appointment expected by calendar year end.
- The team are in the process of tendering a refreshed consultant advisory team in parallel with the new Project Management team.
- New schemes are continuing to be developed through the revised Capital Review Group and will be delivered throughout FY18/19 against a plan that reflects the Trust’s priorities and the departments delivery capacity.

Chart 4: Significant Commercial Variation on Projects in FY18/19:

The following schemes have had significant commercial uplifts to their contract values in FY18/19:

- Bridge House (£353k increase): Driven by numerous small value additional elements requested by the service to support operational readiness. A lesson learnt workshop has been held and the outcome paper approved by CRG in October 2018 with key lessons being implemented across the capital programme.
- NAU Refresh (£0k increase): Programme slippage has been driven by poor performance of the contractor.
- CAMHS PICU (£376k): Driven by escalated working arrangements to arrest programme delays, the addition of an air lock to the DHU, additional costs associated with the family unit and the re-tendering of the Tyson House portion of the works to ensure a more robust scope.
Since the M02 FY18/19 Trust Board report the CEF Departmental Budget has been re-baselined for FY18/19 to allow for pay uplifts and utilities inflation.

- M06 YTD actual spend is £15,248k, a variance of £254k or 1.7% above plan.
- M06 in-month actual spend is £2,392k, a variance of £142k or 5.6% below plan.
- M06 variance caused by the transfer of costs previously coded as revenue (£47k), VAT credits relating to FY17/18 Maudsley electricity costs (£25k) and additional funding for utilities covering the FY to date period (£122k).
- M06 YTD overspend is driven by a to be confirmed inflationary uplift for a third-party contract and rental increases.
- Forecast spend to year end as of M06 is £29,832k, a variance of £20k or 0.07% above plan.

Chart 5: CEF Departmental: Operating Budget Spend Against Plan M06 FY18/19:

Chart 6: Estates: M02 In Month Reactive Call Response Rate % YTD FY18/19:

- M06 Priority 1 (1-2 Hour Response & Close Out): 2 of 6 jobs closed within KPI (33% target 100%)
- M06 Priority 2 (2-4 Hour Response & Close Out): 40 of 55 jobs closed within KPI (73% target 90%)
- M06 Priority 3 (2 Day Response & Close Out): 1373 of 1689 jobs closed within KPI (81% target 70%)
- A deep dive review of the data has been undertaken for M03 to M06 with a focus on the Priority 1 flagged calls. The Estates team has confirmed that no genuine Priority 1 calls were left unresolved outside of the agreed KPI’s.
- In quarter Priority 1 performance was driven by continued erroneous raising of calls to the Priority 1 code. Two of these were attended and closed within the KPI timescale however of the remaining number two were linked to UHL and could not be closed out within the 2-hour window and two were deemed not Priority 1 and dealt with appropriately.
- In quarter Priority 2 performance was also driven by incorrect coding of reactive jobs and for those that were coded correctly they are not being closed out on the system in a timely fashion despite being attended within the SLA as previous reporting periods.
- New PDA units have been distributed and the new software is up and running. As the commissioning period ends the team expects the response data to reflect the improved systems.
- The Estates team are continuing the process of clarifying the Priority Codes, reporting policy and SLA’s which will be communicated with all site teams and users as required. Further work is being undertaken to address appropriate escalation procedures for users.
- The team is liaising with UHL to understand how best to manage reactive calls that require coordination between the two Trusts.
Special Note: Please be advised that the M06 Gas performance drop was caused by the late upload of several reports driven by a change of contractor, these will be fully rectified in M07.

Air – Specialist Extract
- **Performance:** No Comment Required as 100% Compliant.
- **Assurance:** Kitchen ducts are inspected and cleaned on a 6-monthly basis by a third-party contractor (Camfil); Workshop LEV Systems are inspected and serviced on an annual basis by a third-party contractor (P&J Dust Extraction Ltd).

Anchor Points:
- **Performance:** No Comment Required as 100% Compliant.
- **Assurance:** Inspections carried out by SAS annually. ROSPA registered. MiCAD schedules then updated.

Asbestos:
- **Performance:** 99.49% - Deviation caused by an outstanding document request from Live in Guardians at Maudsley.
- **Assurance:** Management Surveys carried out by TRAC Associates once (unless there is a material change to an existing building fabric, a previous survey was inaccurate, the Trust acquires a new asset, substantial removal works are undertaken, or regulations change) then the reports uploaded to MiCAD Compliance Module by TRAC Associates and uploaded to MiCAD Asbestos Register by CEF staff. Trust plan updated every six months, regular working group meetings held.

Assurance Report:
- **Performance:** 99.14% - Deviation caused by an outstanding boiler assurance site visit.
- **Assurance:** Ashdale engineering carries out independent Statutory Engineering Inspections on boilers safety valves, lifts, lifting equipment and pressure vessels on an annual basis. MiCAD status reports are supplemented by regular contractor meetings.

Electrical:
- **Performance:** 99.42% - Deviation caused by Emergency Lighting elements, including works currently underway and outstanding documentation that has been requested.
- **Assurance:** Emergency Lighting testing undertaken in-house on an annual basis. Fixed Wire testing undertaken BS7671 on a 5-yearly basis (next due in FY 19/20). PAT testing carried out by Norwood Electrical on an annual basis. Regular contractor meetings inform the above.

Fire:
- **Performance:** 94.56% - Deviation caused by: Fire Alarm Tests, 1 week behind schedule with 17 documents due; Fire Equipment Testing, testing and certification outstanding but scheduled.
- **Assurance:** Fire alarms tested by Gretton Ward on a six-monthly basis. Dry Riser and Fire Fighting equipment inspections carried out by Standby Fire on an annual basis. Fire Risk assessments carried out in-house every five years, Fire Safety audits carried out in-house on an annual basis.
Gas:
- **Performance:** 61.96% - Deviation caused by failure of previous contractor to complete major servicing to gas appliance within the contractual timescale. New provider (Argent FM) have put together a schedule to address this but the Trust are still awaiting 35 outstanding documents.
- **Assurance:** Trust wide inspection contract with Argent FM, boilers and gas cookers inspected on a six-monthly basis. Statutory inspections undertaken by Ashdale on a six-monthly basis.

Lightening Protection:
- **Performance:** 98.08% - Deviance caused by outstanding actions with new supplier and outstanding documentation from UHL.
- **Assurance:** Annual testing by Omega (new supplier as of M02 FY18/19) on an annual basis to BSEN 62305.

Legionella:
- **Performance:** No Comment Required as 100% Compliant.
- **Assurance:** Independent auditor (RM Associates, Dr Jane Tinkler). Water Risk assessments updated every two years, water coolers sanitised on a six-monthly basis.
CEF Directorate Performance Overview at M06 FY18/19

Chart 1 Strategic Capital Schemes Update: Programme & Spend at M06 FY18/19

Douglas Bennett House (DBH) and Children & Young Persons (CYP):
- Stage 3 contracts of the P21+ process are being prepared for DBH.
- Next steps for CYP being evaluated by consultant and legal advisors.
- See narrative portion of paper for further information.

Chart 2 DBH: Cumulative Cash Flow YTD M06 FY18/19

Chart 3 Capital Planning: Significant Commercial Variation on Projects in FY18/19

<table>
<thead>
<tr>
<th>Project</th>
<th>Original Budget (£)</th>
<th>Original Completion Date</th>
<th>Revised Cost 1 (£)</th>
<th>Revised Cost 1 Date</th>
<th>Revised Cost 2 (£)</th>
<th>Revised Cost 2 Date</th>
<th>Revised Cost 3 (£)</th>
<th>Revised Cost 3 Date</th>
<th>Revised Completion Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>Bridge House</td>
<td>£250k</td>
<td>--</td>
<td>£600k</td>
<td>March 2018 SMT</td>
<td>£742k</td>
<td>April 2018 SMT</td>
<td>£1,095k</td>
<td>November 2018</td>
<td>October 2018</td>
</tr>
<tr>
<td>NAU Refresh</td>
<td>£250k</td>
<td>February 2018</td>
<td>£330k</td>
<td>April 2018 SMT</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>August 2018</td>
<td>December 2018</td>
</tr>
<tr>
<td>CAMHS PCU</td>
<td>£332k</td>
<td>--</td>
<td>£600k</td>
<td>October 2017 CRG</td>
<td>£830k</td>
<td>October 2017 CRG</td>
<td>£1,206k</td>
<td>July 2018 CRG</td>
<td>March 2018</td>
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</tbody>
</table>

Chart 5 Capital Planning: Cumulative Capital Planning & Estates (Excluding Strategic and FI) Spend Against Plan M06 YTD FY18/19

Chart 6 Estates: M06 In Month Priority 1, 2 & 3 % Reactive Call Response and Priority 3 & 2 Open Call Nov YTD FY18/19

Chart 7 Estates: Compliance Risk Assessment Completion M06 FY18/19

Page 99 of 114
A – BME event with Yvonne Coghill

On 13th November, the Board, together with staff from across the Trust, attended an all-day session with Yvonne Coghill, Director of Workforce Race Equality Standard (WRES) Implementation at NHS England. The event brought together BME staff, managers from a range of different teams, and our Board of Directors to explore the experiences of our BME staff and to identify ideas for improvement.

It was a very worthwhile day. We had an open conversation about race and it helped us all to understand more about the day-to-day experiences of our colleagues. We spent some time considering the key indicators for WRES success and what we needed to improve for the future. We received some good feedback from Yvonne Coghill and her colleagues about our current WRES action plan, as well as some ideas for further improvements. Our plan has been designed by our ‘Snowy White Peaks’ group involving the Chair of our BME Network as well as our Non-Executive Director, Mike Franklin, as well as members of the executive team.

Thanks to the commitment of our staff, and the excellent facilitation and contribution by Yvonne and her team, we ended the day with a real sense of optimism and energy for driving this agenda forward and ensuring that SLaM is a great place for everyone to work.

B – Quality Improvement event

The first South London Partnership Quality Improvement conference took place on Thursday 8 November at the KIA Oval. Attended by nearly 300 people including staff, service users and carers from the three organisations (SLaM, Oxleas, and South West London and St George’s), it was a fantastic celebration of the achievements of staff across the South London Partnership and an
opportunity to learn from each other through breakout sessions, poster submissions and networking.

External speakers included Johnathan MacLennon from NHS Tayside and Institute of Healthcare Improvement who spoke about the importance of building the will, starting small and learning from failure. Samantha Riley from NHS Improvement spoke about the essential knowledge you need to get more from your data at her session "Making data count". During the afternoon the emphasis was on the importance of co-production and the value of lived experience in quality improvement.

C – South London Mental Health and Community Partnership leadership event

Senior Leaders from across the South London Partnership met on 12th November to take stock of progress across the partnership and to discuss vision and future plans. It was a chance for our leaders in each of the trusts to meet the new Oxleas Chief Executive, Matthew Trainer, and to hear about the major programmes under way and substantial benefits being delivered.

The event revealed a strong commitment across each of the Trusts to reap the benefits of closer working across a range of different work areas with a view to benefitting patient care and driving further improvements.

D – Award Winning staff

I was delighted to be able to present the award for Psychiatric Team of the Year (‘Working-age adults’ category) at the RCPsych Awards 2018 to our KHP Pathway Homeless Team.

This fantastic multi-disciplinary team works to improve health and housing outcomes for inpatients who are homeless or vulnerably housed. It provides holistic, integrated care for homeless people attending King’s Health Partners trusts – Guy’s and St Thomas’, King’s College Hospital and SLaM. The judges were particularly impressed the way the team have supported a culture shift in the way homelessness is treated within the Trusts. They were also impressed by the rigorous evaluation of the effectiveness of the service.

I would also like to congratulate Dr Graham Blackman, who was shortlisted for the Core Psychiatric Trainee of the Year (CT1-CT3) award. Dr Blackman is Clinical Research Fellow at the Institute of Psychiatry, Psychology & Neuroscience at King’s College London, and was previously Academic Clinical Fellow at SLaM. His research, supervised by Professor Anthony David, focused on the role of immune dysfunction in neuropsychiatric disorders.

My warm congratulations to them all for their well-deserved success.

Dr. Matthew Patrick
REPORT TO THE TRUST BOARD: PUBLIC

27 November 2018

<table>
<thead>
<tr>
<th>Title</th>
<th>Council of Governors’ report</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>
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</tbody>
</table>

**Purpose of the paper**

To update the Board on the recent activity of the Council of Governors

**Governor elections**

Voting in the recent Governor election process closed on 5 November 2018. Simon Darnley was re-elected unopposed in the staff category, which leaves a vacancy in this constituency. The Membership and Involvement Working Group plans to look at how to engage more staff members in the work of the Governors and thereby encourage more staff to stand for election.

Brian Lumsden, Deputy Lead Governor, was re-elected in the public constituency and will be joined by Professor Michael Kopelman. Ray Baker and David Clugston were elected in the service user category, as was a third person whose name will be confirmed once they have responded to the notice of their election and confirmed their intention to accept the role.

All new Governors will take up their posts on 1 December. An induction day scheduled for 15 November unfortunately had to be postponed owing to unforeseen circumstances, but new Governors (plus Governors from Oxleas and Guys and St Thomas's) are attending bespoke core Governor training from Governwell, hosted by SLaM, on 20 November and the induction day will now take place in early January.

**Meeting with NEDs – 30 October**

Governors met with the NEDS ahead of the Board meeting and raised questions about patient flow, bed capacity and the Trust’s financial position.

**Membership & Involvement Working Group – 1 November**

The group received a presentation from Christine Andrews, service user Governor, on her role in the Mind & Body programme. The group also agreed its priorities for the forthcoming year, which include engaging with staff to raise awareness of the Governor role with a view to increasing staff candidates at next year’s CoG elections; helping to deliver the Changing Lives strategy; and capturing and disseminating the learning from Governor activity in the community (thereby contributing the Governors’ responsibility to represent members and the public).
Quality Working Group – 7 November

The group was updated on – and gave feedback in response to - plans to develop a new Family and Carers’ Strategy as the current one expires in 2019. Governors were also joined by Dr Isabel McMullen, Consultant Liaison Psychiatrist, who gave an overview of the challenges and pressures related to treating people suffering mental health crisis in Emergency Departments. The group was joined by two NEDs, Anna Walker and Geraldine Strathdee.

Planning and Strategy Working Group – 13 November

At the Governors’ request, the group heard from the Chief Financial Officer on current financial challenges faced by the Trust, and from the Director of Strategy and Commercial on the refresh of the Changing Lives strategy. Roger Paffard, Trust Chair and Chair of the Council of Governors, also joined the meeting.

South London Mental Health and Community Partnership QI conference – 8 November

The first South London Partnership QI conference took place on Thursday 8 November 2018 at the Kia Oval, and four SLaM Governors attended and met the Lead Governor from Oxleas. The conference was arranged for staff from each organisation to network, celebrate successes and share learning about how they are working with staff, patients, carers and partners to improve patient care.

Bids Steering Group – 22 November

The group is due to meet on 22 November to receive an update on the current Smile Together scheme and to start planning for the 2019 scheme.

Meeting with Lambeth CCG

A small group of Governors are due to meet representatives of Lambeth CCG on 5 December.
Title | MENTAL HEALTH LAW COMMITTEE – 20 SEPTEMBER 2018
---|---
Non-Executive Director | Beverley Murphy, Director of Nursing

**Purpose of the paper**

1. This is a regular report to the Board which sets out:
   - the key issues discussed at the Trustwide Mental Health Law Committee meeting on 20 September 2018 and the actions proposed and progress made
   - 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 7: Quality & statutory compliance
- BAF Risk 3: Informatics
- BAF Risk 13 – Mandatory training

**KEY ISSUES SUMMARY**

The September Committee considered trust performance against legal standards during quarter one (April – June 2018) of the financial year including the use of the commonest applied S2 and S3 assessments in the community, and importantly the delays to these Mental Health Act assessments taking place and/or patient access, once detained, to the ‘appropriate’ care needed. During the reporting period over 160 MHA assessments were delayed with 37% being due to lack of bed availability.

The Committee also considered urgent care S136 detentions when a person had been detained in the Health Based Place of Safety beyond the legal detention period of 24 hours. 29% (48) of all those detained (162) stayed beyond the statutory 24 hours due to no bed availability.

**Trends and Actions in progress to address key issues**

- **Strengthened Board to floor Governance:** The trust has established new Operational Directorates Mental Health Law Committees to ensure local services are sighted on the standards and can put in place responsive action to deliver, with partners, the necessary improvements. The Trustwide Committee will support improvement actions that can be most effectively and efficiently developed, delivered or progressed at Trust wide level.

- **Strengthened Informatics:** The Trust will implement the Mental Health Law informatics workplan and improve its information reports to provide more detailed
being available for admission.

The Committee reviewed data for patients Absent Without Leave (AWOL) for quarter 1 which showed a downturn in the total number of AWOLs across the trust from 70 to 52 within the quarter. 20% of the AWOLs were where the patient absented themselves from the ward or garden. Improvements were highest in Gresham 2 ward where the Deputy Director of Nursing and Patient Experience had done some specific quality improvement work with the ward team.

The Committee noted that, from information available in the CEO Cavendish Square group MHA data, 50% of all patients detained in the community were transported to hospital in a police vehicle, which is a breach of the Code of Practice requiring Pan London action.

<table>
<thead>
<tr>
<th>CQC Regulatory fundamental standards of care</th>
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<tbody>
<tr>
<td>The Committee received five CQC Mental Health Act Monitoring reports undertaken in quarter 1. 17 patient records were accessed and 20 patients seen in private on five units. Demonstrated improvements had occurred in areas such as internet access for patients and the use of section 17 leave forms. However, consistently cited breaches of fundamental standards of care included accurate and detailed recording of capacity and consent assessments, offering patients their rights under section 132 repeatedly, involvement of service users in coproduced care plans and offering patients the fundamental NICE standards of care and the necessary range of therapeutic activities.</td>
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</tbody>
</table>
| The new CQC Insight Report on Quality Standards – includes information on the application of the Mental Health Act. The report identified that in the period 1 March 2017 to 28 February 2018 of the 513 Second Opinion Appointed Doctor (SOAD) visits requested to assure medication prescribing - 30% of these were requested later than the required due date of one month (for community patients) or three months (for detained patients).

The CQC Insight Report indicates that in 19% of the SOAD visits there were “Problems reported by SOADs with the administration of the visit, e.g. paperwork/consultees/patient not available etc. This includes problems reported during SOAD visits for CTO patients, where non-attendance of patients may not be the direct fault of the provider that requested the visit.” |
| The CQC local findings will be presented at the Operational Directorate Mental Health Law Committees and progress against actions presented to the December Mental Health Law Committee by the local Committee Chairs. Accessible information standards are being improved in the Trust communications programme including provision of information on the outward facing Trust website and trust intranet. Mental Health Law notice boards are being considered for implementation on all wards. The Mental Health Law information available in the trust is being revised to make this more accessible and clearer for our service users and carers. Copies of the information is being made available in a printable format on the trust intranet and website which can be printed by wards for local use. The Trust CQC improvement plan includes reviewing the standards of NICE implementation identified in the Trust audit programme, including for detained patients. The communication of expected standards of care for all MDT staff is in progress for inclusion in job planning, supervision and appraisal. To improve the medicines related aspects of MH Law performance, the Chief pharmacist has been asked to join the Trustwide Mental Health Law Committee |

| clinical information direct to the Local Operational Directorates to help them prioritise improvements needed. |
| Continuous Improvement actions: The Executive team and local Operational Directorates will continue to implement access to beds and flow improvement actions. Eight MADE events are already booked and the trust Board agreed a robust Winter pressures programme that will support the improvement of MH act standards. The Director of Nursing oversees a successful programme of the reduction of restrictive practices and AWOLs and will prioritise the 10 units with the highest need for improvement support. |

- The CQC local findings will be presented at the Operational Directorate Mental Health Law Committees and progress against actions presented to the December Mental Health Law Committee by the local Committee Chairs.
- Accessible information standards are being improved in the Trust communications programme including provision of information on the outward facing Trust website and trust intranet. Mental Health Law notice boards are being considered for implementation on all wards.
- The Mental Health Law information available in the trust is being revised to make this more accessible and clearer for our service users and carers. Copies of the information is being made available in a printable format on the trust intranet and website which can be printed by wards for local use.
- The Trust CQC improvement plan includes reviewing the standards of NICE implementation identified in the Trust audit programme, including for detained patients. The communication of expected standards of care for all MDT staff is in progress for inclusion in job planning, supervision and appraisal.
- To improve the medicines related aspects of MH Law performance, the Chief pharmacist has been asked to join the Trustwide Mental Health Law Committee.
### 2018/2019 Workplan to deliver the Term of Reference requirements and Improved Board to floor Governance:
The Committee welcomed the hard work that had gone into producing the four components of the new work plan designed to improve standards. The four work plan components are a) Governance, b) Informatics, c) Training and d) Improvement, including Quality improvement and digital enablers.

The Mental Health Law Committee reiterated that the new work plan is needed to assure that the trust both meets the legal and CQC regulatory standards in our use of the MHA and that the care provided to those people we detain delivered is of ‘appropriate’ high quality and delivered in a way that meets our human rights and equalities requirements, uses the least restrictive practices and meet the Accessible Information Standards.

### Work plan on Accessible Information, informatics and digital
A Task and Finish informatics Group produced a set of work plan recommendations which were agreed at the Trust wide Mental Health Law Committee on 20 September 2018. This includes:

- The establishment of an expert Mental Health Law informatics group with the right range of skills to design the analyses required to provide assurance on the two components of the revised Terms of Reference i.e. that SLaM meet its legal and regulatory requirements and that those detained receive the most ‘appropriate’, least restrictive high quality of NICE standards of care, in a manner that meets our Human Rights and Equalities (and accessible information) requirements and standards.

- The group can also provide assurance with informed clinical interpretation of the data, and work towards reducing the burden of data collection and analysis through extraction direct from the electronic Patient Journey System (ePJS) where feasible. The group can work to ensure that the data processes across South London Partnership, are consistent and that there is alignment with the Cavendish Square group commissioned Mental Health Legislation data, and with the emerging national CQC data requirements.

- The workplan also set out a feasible sustainable workplan with immediate, short, medium- and longer-term actions and the digital programme has been asked to develop decision support tools to improve timely actions in a low burden way

- With the major reorganisation of the Trust’s services designed to improve services and partnerships and strengthen improvement, new Board to floor and floor to Board governance arrangements have been put in place and will commence work in Nov and Dec.

- In each of the six Operational Directorates, a specific new, or existing governance committee has been identified to review the mental health law standards. The membership of these Committees includes strong local clinical and service leadership, from all multi-disciplinary team disciplines, service users and advocates.

- The Terms of Reference of these committees has been agreed to align with that of the Trust wide Mental Health Law Committee, so that there is clear Board to floor information and workplan flow.

The Trust Informatics plan is progressing with the following immediate actions in progress from Nov to Jan:

- The priority Quality clinical Information available in the MHSDS and EJPS sources on detained patients is being identified so that it can be added to the current basic BI trend data so that the Local Operational Directorates have the essential information they need for their governance. Time to identify capacity and inhouse capability is the time limiting factor.

- Establishment of a sustainable Informatics expert group is essential to make improvement progress

- Review of the CQC Insight report MH Law standards section and new areas for improvement identified as well as areas where we have high standards that can be showcased and rolled out to units that have support needs

- Review of the CEO commissioned pan London MH act dashboard is being undertaken to determine where Slam benchmarks, to identify any key improvements needed and any good
term priorities and will continue to assess the capacity and competency needed to deliver practice we can emulate

| Work plan on training: |  |
|------------------------|--------------------------|--------------------------|
| The Committee received a paper from clinical leaders and the MH Law training lead outlining and reviewing the current mental health law training available within the trust. The training is mainly didactic, is not always codesigned and delivered with service users, cannot assure the more complex capacity competencies. The group set out proposals for improvement in the content, training methods and evaluation to better address the standards where improvement is needed. Following the review of Mental Health Law training, modernisation of the training provided is planned to increase the level of competencies for the clinical care elements where our standards require improvement. These include information giving, consent and capacity assessment and recording, development of coproduction of care plans, development of advance decision self-management and relapse prevention sections in care plans. |
| • An Mental Health Law MDT training group will continue to meet and report into the Trustwide Mental Health Law Committee.  
• A timescale and costed plan will be developed.  
• The Committee agreed that one of Slam’s fundamental standards is that training will always be codesigned and delivered with service users and this will be monitored in all future training.  
• Debriefing post detentions and restraint as a core part of the clinical processes will be encouraged as part of the improvement plan method. |

<table>
<thead>
<tr>
<th>Improving Quality and Quality Improvement</th>
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<tr>
<td>The Committee were informed that there is major commitment to improvement of fundamental standards of care in line with the CQC Improvement plan. To achieve this Medical Director reported that there needed to be a focus on core fundamental standards and improvement methods which includes the strengthened governance, basic information and assurance processes. This means that there is no unique plan for a Quality Improvement (QI) approach to Mental Health Law matters at present, as (QI) is best used for complex clinical and cultural change processes. Noted was that in our leading units there is QI activity e.g. coproduced care planning and CPAs, reductions in restrictive practices that can be rolled out. The immediate priorities for the Trust are to address the lack of beds and safety. If these two priorities are addressed then the MHA assessment delays and overstay s135 and s136 breaches would potentially improve</td>
<td></td>
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</table>
| • Improvement police liaison, MADE events and winter pressures related improvements are in progress  
• A review of the s132 audit cycle improvement method is in progress |

<table>
<thead>
<tr>
<th>Digital improvements</th>
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| Digital improvements are in progress to improve standards, clinician decision support tools, and reduce paperwork to free up time to care  
A proposal for a digital and audit ‘work smart’ project in the Global Digital Exemplar (GDE) programme has been put forward.  
The current method of Mental Health Law compliance assurance has depended on audits. These require |
| • The GDE team and Trust medical digital lead (NB) are scoping the improvement possibilities including a streamlined user coproduced S 62 form.  
• Digital improvements in relation to S 17 forms are in progress  
• The trust has been cited as a leading digital improver in the use of the mental health law |
significant time and resource allocation and enable just an annual snap shot, rather than information that can drive continuous improvement. With the development of ePJS and the GDE programme, the trust is now in a position to determine how reports and clinical decision tools can be embedded, and routine information available to clinicians and clinical teams for continuous in vivo improvement rather than having to wait for an annual audit cycle.

Key points of assurance

Trust intensive Improvement plans to reduce legal and regulatory breaches in Section 135, Section 136, S 2 and S 3 MHA Assessments

- The Trust has put in place intensive improvement initiatives to reduce the legal breaches of delayed MHA assessments and overstays in the HBPoS. These include, in particular, police liaison arrangements to agree community assessment times, eight Multi agency partnership and discharge events (MADE), and winter pressure plans. Weekly data is presented at the Trust Safety Huddle to monitor both issues. The strengthened local Operational Directorate governance will be important.

Strengthening Quality Work Plan to improve governance, information, training and improvement methods

The revised duties work plan is aimed at improving quality in both ToR strands of the standards in relation to the MHA and the equality and quality of the least restrictive care, once a person is detained. An implementation programme is progressing, including:

- Clarity of the Board-to-floor governance arrangements in the borough structures; establishment of Operational Directorate Mental Health Law Committees chaired by Medical Leads, and a strengthened Trustwide committee, with expert by experience and carer members
- Development of informatics strategy to monitor trends, potential for avoidable detentions and improved equality of application of the Act, compliance and reasons for non-compliance and improvement support needed; joint working in place to review Mental Health Law Informatics with the trust senior clinical leadership, Trust Performance Team, Business Intelligence and the Mental Health Law team. A Mental Health Law Informatics Group to be established and the additional new benchmarking information to be summarised as an early priority so that we can learn from best practice within the trust and elsewhere
- Modernisation of Mental Health Law training for MDT disciplines to utilise innovative and competency-based training methods, and user codesign content and delivery aimed at improving standards and a better understanding of the experience of detention for service users and families. Work being progressed with the Education and Training Department.
- Review of the trust’s mental health law related improvement methods to improve compliance and care standards, and reduce paperwork to free up time to care, including, clinically led development of digitalised processes such as s17 leave and s62 medication forms and digital development of clinician decision support tools. A review of the outcomes of audit cycles as the current main improvement method will be undertaken.

Key risks to flag

Delayed MHA Assessments – S 140 failure to provide services including beds, for patients who need admission under the MHA is a breach of the MHA. MHA Code of Practice 14.78 states “Clinical commissioning groups (CCGs) are responsible for commissioning mental health services to meet the
needs of their areas ......” Delays with MHA assessment completion poses a risk to the patient and potentially other persons and has been identified by CQC as a national concern.

**Section 135 and section 136 regulatory** - overstays by persons in the Health Based Place of Safety (HBPoS) beyond the 24-hour assessment period for the section 135 or 136 places the Trust at risk of detaining a person without the legal authority to do so. This is an issue of concern to this Trust and our partners in the South London Partnership as well as Trusts in the wider London region. Legal advice provided does not identify solutions that are possible for us to implement.

**The new CQC Insight Report on Quality** Standards – this includes information on the application of the Mental Health Act. The report identified that in the period 1 March 2017 to 28 February 2018 of the 513 Second Opinion Appointed Doctor (SOAD) visits requested to assure medication prescribing - 30% of these were requested later than the required due date of one month (for community patients) or three months (for detained patients). The CQC Insight Report indicates that in 19% of the SOAD visits there were “Problems reported by SOADs with the administration of the visit, e.g. paperwork/consultees/patient not available etc. This includes problems reported during SOAD visits for CTO patients, where non-attendance of patients may not be the direct fault of the provider that requested the visit.”

Discussion is in progress with the ePJS Development Team to explore how the trust can capture its own data on this aspect of the MHA to link the Epjs MHA record with the CQC SOAD request portal in a streamlined manner that supports clinical decision making and frees up time to provide clinical care.

**MHA Governance in Acute Trusts** -
SLaM provides clinical services i.e. Liaison mental health teams, and administrates the use of MHA in four partner acute Trusts under a service level agreement. There is a need to understand the governance that is in place in the acute trusts to ensure the that the support infrastructure and resources available to the liaison teams meet legal and PLAN i.e. RCPsych liaison peer accreditation standards for safety and least restrictive treatment of detained people. This will be similar to the Trust’s governance arrangements for Alliance contracts, prison services, primary care and other outsourced services.

A report of MHA activity and governance arrangements will be presented to the December meeting of the Trustwide Mental Health Law Committee.

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

The issues highlighted in the key issues summary report for the Board have been reported to the November 2018 Quality Committee.

The equalities issues identified have been communicated to the Workforce and Equalities work programme and responsive improvement action is being developed
Title | Improvement Plan Oversight and Scrutiny Group
---|---
Non-Executive Director | Geraldine Strathdee

**Purpose of the paper**

This is a regular report to the Board which sets out:
- the key issues discussed at the Group and the actions proposed;
- the key points of assurance;
- the key risks that the Chair or the Group 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**

Key BAF risks relevant to this paper are 7, 11, 3 and 2:
- BAF Risk 2: Operational delivery structure
- BAF Risk 3: Informatics
- BAF Risk 7: Quality & statutory compliance
- BAF Risk 11: QI delivery

**KEY ISSUES SUMMARY**

<table>
<thead>
<tr>
<th>The acute pathway received an inadequate rating due areas of concern and this resulted in a Regulation 29A (HSCA) warning notice regarding the Acute and PICU pathway. The priority areas for improvement in the pathway are:</th>
<th>Monthly Oversight and Scrutiny committee meetings are set</th>
</tr>
</thead>
<tbody>
<tr>
<td>(i) Fundamental standards of care</td>
<td>The trust reorganisation into local operational delivery units with strengthened governance, is enabling more rapid, responsive improvement plans and action in the four priority areas across the acute pathway</td>
</tr>
<tr>
<td>(ii) Governance</td>
<td></td>
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<tr>
<td>(iii) Leadership and culture</td>
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<td>(iv) Clinical pathways including flow and discharge planning.</td>
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<tr>
<td>The Trust established an Oversight and Scrutiny Group which has met in Sept and October</td>
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</tbody>
</table>
### Improvement planning meetings have been put in place with good staff engagement: these include the Delivery Board, Quality Portfolio Board and the Flow Meeting.

The local operational delivery units feed into these meetings, having each set out plans to address the ‘should do’ and ‘must do’ priority actions and are progressing implementation of the improvement actions through their new governance structures.

The reporting of the measurable improvement progress needs to be strengthened to enable oversight. The local operational delivery units are developing strengthened local governance arrangements, implementation of their improvement plans. Their new integrated quality, performance and activity reports, and the commitment to improve data quality, were welcomed at the October Quality Committee.

The teams and improvement actions that require the most intensive support are being identified. Through the agreed KPIs the CEO and senior leadership team will be alerted to progress and improvement actions needed and the leadership workstream will be asked to support. These issues are being taken forward by the teams and escalated in Delivery Board and Quality Portfolio Board.

The extraordinary October Quality Committee meeting and the routine October QC meeting welcomed the progress reports and requested that priority be given to the flow of information from floor to Board necessary to assure improvement across the acute pathway, including inpatient and community teams for the immediate, and longer-term actions.

The Quality Committee is supporting the development of the business as usual (BAU) revised governance processes and Quality information flows, following the reorganisation of trust services. This will add assurance to the targeted, immediate, short term work of the OSG, and build in sustainability for the medium- and longer-term improvements. The identification of the issues that can be tackled in each local operational delivery unit and those that require

### Key points of assurance

**Assurance:**

- Improvement plans for each operational delivery unit and an aggregated trust wide plan have been developed in line with the CQC requirements
- These plans contain commitment to improved operational management delivery processes, Fundamental Standards of Care, and to clinical care improvements in line with evidence based NICE and professional standards of care & outcomes requested by service users and families
- The Exec team report significant involvement and ownership by service and clinical directors and staff at all levels in the improvement plans
The CEO has given very clear guidance about the Mental Health Compact deliverables & the top level key progress metrics he expects.

The agreed priorities to ensure delivery of the plans is now to:

- Put in place a process of clear identification of the teams and units that require prioritised improvement support, with clear KPI progress metrics & ‘alert’ functions to illustrate improvement delivery, and enable rapid identification and resolution of any challenges to progress (in addition to the self-reported QuESTT scores)
- Develop clear BAU governance, informatics, QI processes in the reorganised operational delivery units to ensure floor to board and board to floor delivery, in line with the CQC requirements for well led strengthened governance, in particular feeding into the Quality Committee & MH Law committee
- The risks to delivery due to external factors including rising demand, capacity and the deficits in Mental health standard resources, are being delineated & transformational initiatives planned such as winter pressure and flow bids
- The Flow meeting is still developing and needs clearer tracking of progress of plans and implementation and tracking of the agreed flow actions.
- The Board will receive the Fundamental Standards of Care paper and operational delivery policies which ensures that all staff across the organisation are aware of the standards expected in Slam in line with the CQC ‘must dos’ and should dos’ and the identified culture change requirement

**Key risks to flag**

- The immediate plans to tackle the ‘must dos’ and ‘should do’ priorities for the next 5 months to meet the CQC agreed requirements could be overshadowed by the improvement plans for the medium and longer term.
- By contrast, whilst the current plans address ‘must do’ and ‘should do’ action, there is little objective assurance that the issues they pertain to will not arise again in different but similar form – the sustainability agenda has yet to be properly addressed.
- Data – both covering board/middle management/ team to ward visibility and priority of actions for the improvement plan has been slow to develop and whilst improving, is not yet wholly coherent, comprehensive and without overlaps
- The plans will need to be supported by reports extracted from our informatics – manual reporting will be inaccurate and slow
- The capacity in the PMO (Project Management Office) will need to be strengthened
- Rising demand due to social determinant and other local population and commissioning of trigger factors & compromises in commissioning and provision of NICE quality care plans
- Quality to meet NICE standards and develop advance decision care plans

**Issues to be brought to the attention of other Committees and Meetings**

- Capacity in the PMO and BI and clinical informatics teams and a responsive trust informatics strategy
- The urgent need for a streamlined set of outcome and process performance data
- The urgent need of visibility of priority actions taken within our most troubled wards and teams.
REPORT TO THE TRUST BOARD: PUBLIC
November 2018

<table>
<thead>
<tr>
<th>Title</th>
<th>Board Deep Dive programme and Board development priorities</th>
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<tbody>
<tr>
<td>Author</td>
<td>Rachel Evans, Director of Corporate Affairs</td>
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Purpose of the paper

To agree the Board priorities and Board Deep Dive programme up to July 2019.

1. Board Deep Dive programme

The following programme is proposed. Michael Holland is exploring with NHS Improvement whether we might be able to duplicate the sessions being provided for those Trusts who were successful in joining the NHSI Quality Improvement Leadership programme.

<table>
<thead>
<tr>
<th>Dates</th>
<th>Deep dive – scheduled items</th>
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<tbody>
<tr>
<td><strong>Tuesday 27 November</strong></td>
<td>Research and Innovation, led by Prof Ian Everall and Matthew Hotopf</td>
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<tr>
<td><strong>Thursday 13 December</strong></td>
<td>Progress on CQC Implementation plans (to include floor to Board data and governance and focus on Community developments)</td>
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<tr>
<td><strong>Tuesday 29 January</strong></td>
<td>Making best use of benchmarking data - Michael</td>
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</table>
| **Thursday 14 March** | (a) Strategic plan – outcomes, metrics etc. (follow up to the Strategy Communications documents agreed in September / October) – Altaf (60 min)  
(b) Finance reporting of Alliance contracting etc. - Gus (30 min) |
| **Monday 21 – Tuesday 22 May** | (a) How are we delivering a step change in our relationship with our service users and carers?  
(b) Population Health  
(c) Freedom to Speak Up (as agreed in the October Board paper) |
| **Tuesday 23 July** | [Hold for possible Quality Improvement Leadership slots] |

2. Board Development priorities

Following discussions, we are proposing three priorities for the coming two terms: (1) Use of data and benchmarking, (2) QI Leadership and (3) BME inclusion. A programme of activity is being developed.
# Board of Directors Meeting

**To be held 18th December 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
2:30pm

- Welcome, apologies for absence & declarations of interest and Conflicts of Interest Register

### Quality
2:45pm

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<td>Patient/Carer Story</td>
<td>Gabrielle</td>
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<td>Risk Focus: BAF Risk – tba</td>
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<td>Quality &amp; Performance Report</td>
<td>Matthew</td>
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<td>Learning from Deaths</td>
<td>Michael</td>
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<td>Q2 Lessons Learned</td>
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<td>CAMHS Paper</td>
<td>Harold/Michael</td>
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<tr>
<td>Finance Report (longer slot)</td>
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### Updates

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<td>Board Assurance Framework</td>
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<td>Quality Committee Update</td>
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<td>Mental Health Law Committee Update &amp; Annual Report</td>
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<td>Business Development Investment Committee Update</td>
<td>Adam</td>
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<td>Finance &amp; Performance Committee Update</td>
<td>Stephen</td>
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<td>Brexit Preparations Update</td>
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### For Noting

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<td>Kate</td>
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<td>Report from previous month’s Part II</td>
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<td>Wrap-up &amp; Next Meeting</td>
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<tr>
<td>Meeting Evaluation</td>
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<td>Verbal</td>
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The next Board of Directors Meeting will be held on 29th January 2019  
2:30pm at the ORTUS, Learning Centre, 82-96 Grove Lane, SE5 8SN, Maudsley Hospital

Please note that minutes may be subject to Freedom of Information requests 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