Board of Directors Meeting
To be held 26th February 2019
2:30pm - 5:00pm ORTUS, Maudsley Hospital

AGENDA: Part 1

Opening Matters
21/19 Welcome, apologies for absence & declarations of interest
22/19 Minutes, Action log review

Quality
23/19 Patient Story
24/19 Developing the next King’s Health Partners 5 year Plan
25/19 Director of Public Health Annual Report – first 1000 Days
26/19 Performance & Quality Report
27/19 Community Services Redesign Plans and Progress
28/19 The Quality Centre – Next Steps
29/19 Capital, Estates & Facilities Dashboard

Value
30/19 Finance Report

Updates
31/19 Chief Executive’s Report
32/19 Council of Governors Update
33/19 Quality Committee Update
34/19 Business Development & Investment Committee Update
35/19 Mental Health Law Committee Update

For Noting
36/19 Feedback from NED/Governor visit to Ladywell Unit
37/19 Health and Wellbeing Board Health and Care Plan
38/19 Wrap-up & Next Meeting
39/19 Meeting Evaluation – Beatrice Butsana-Sita

The next Board of Directors Meeting will be held on 26th March 2019
2:30pm, at the ORTUS, Learning Centre, 82-96 Grove Lane, SE5 8SN.
Maudsley Hospital

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

web site: www.slam.nhs.uk
MINUTES OF THE HUNDRED AND TWENTY-FIFTH MEETING OF THE BOARD OF DIRECTORS OF THE SOUTH LONDON AND MAUDSLEY NHS FOUNDATION TRUST
HELD ON 29 JANUARY 2019

PRESENT
Roger Paffard Chair
Béatrice Butsana-Sita Non-Executive Director
Rachel Evans Director of Corporate Affairs
Mike Franklin Non-Executive Director
Duncan Hames Non-Executive Director
Gus Heafield Chief Financial Officer
Dr Michael Holland Medical Director
Altan Kara Director of Strategy and Commercial
June Mulroy Non-Executive Director
Beverley Murphy Director of Nursing
Dr Matthew Patrick Chief Executive
Sally Storey Associate Director of People and Organisational Development
Dr Geraldine Strathdee Non-Executive Director
Anna Walker Non-Executive Director

IN ATTENDANCE
Ermias Alemu Governor
Rod Booth Director of Contracts, Performance and Operational Assurance
Jenny Copley Governor
Simon Darnley Head of Nursing, Lambeth
Bronwyn Dewing Acting Deputy Director, Lambeth
Emily Finch Clinical Director
Angela Flood Governor
Cath Gormally Former Director of Social Care
Kathryn Grant Governor
Barbara Grey Director QI and SLaM Partners
Michael Hembest Healthwatch Croydon
Charlotte Hudson Deputy Director of Corporate Affairs
Jo Kent Service Director
Russell Mascarenhas NExT Director
Zoë Reed Director of Organisation and Community and Freedom to Speak up Guardian
Paul Richards Head of Social Care, Croydon
Sue Scarsbrook Governor
Gill Shaple Governor
Hugh Williams Guardian of Safe Working

APOLOGIES
Kristin Dominy Chief Operating Officer
Mary Foulkes Joint Director of People and Organisational Development
Professor Ian Everall Non-Executive Director

BOD 01/19 WELCOME, APOLOGIES FOR ABSENCE, DECLARATIONS OF INTEREST
REGISTER (14.55)
Apologies were taken as above. Vanessa Smith, Service Director for Psychological Medicine and Older Adults, was welcomed to the table as she was shadowing the Director of Nursing.

**BOD 02/19 MINUTES, ACTION LOG REVIEW (14.57)**

The minutes of the last meeting were confirmed as accurate. There was one overdue action relating to the Trust’s progress against The Mental Health Units (Use of Force) Act; an update will be provided in February. The responsible Director is now the Director of Nursing, not the Medical Director.

The development of the Performance and Quality report will remain on the action tracker until it reaches an agreed format and structure.

**BOD 03/19 BOARD LEVEL REVIEW OF SERIOUS INCIDENT (14.59)**

Simon Darnley, Head of Nursing for Lambeth, and Bronwyn Dewing, Acting Deputy Director for Lambeth, attended the meeting to present a review of actions taken as a result of a fire which broke out in a patient’s bedroom on Luther King Ward (Lambeth Hospital) in July 2018.

Geraldine Strathdee noted that the patient had been under SLaM’s care since they were 18, and had been re-admitted a number of times, and wondered whether there were processes which could have meant that this incident was avoided. Bron Dewing explained that the patient had no history of arson, so it would have been very difficult to predict. She added that the patient had not been charged with any offence, but there were no other suspects for the arson.

The incident had highlighted that the fire panel had not accurately identified the location of the fire; where works had been undertaken and room numbers changed, this had not been reflected. As a result of this, 90% of Trust buildings have now been revisited and tested for this issue and zone plan drawings implemented. The remaining 10% will be checked in the next two weeks. The porters have confirmed that fire procedures have been updated and an escalation procedure put in place.

The Board considered the application of searches, and the Trust-wide smoking policy. They were reminded of the conversation at November’s Board meeting about the level of search that is appropriate. Beverley Murphy pointed to a national piece of work looking at the risks and benefits of using metal detectors which found that they pick up some risks, but not all. The most effective way to mitigate the risk is through proactive therapeutic engagement and robust clinical risk assessments.

The presenters were asked if there was anything specific that they wanted the Board to know. Simon Darnley reflected that staff had evacuated patients to the garden, instead of deploying a horizontal evacuation (keeping two doors away from the fire) because they did not feel the latter was a safe option. He asked the Board to consider the line between Trust policy and what staff feel comfortable doing.

Matthew Patrick noted that he had visited the ward the day after the incident and found them to be an impressive group of staff.

Anna Walker pointed to a meeting she is due to have with the Director of Nursing and Head of Risk Assurance to look at quality risks associated with Health & Safety legislation compliance.
Beverley Murphy and Rod Booth introduced the third iteration of the Performance and Quality (P&Q) report. The second round of P&Q review meetings have now been held with each operational directorate and the data in the Board report reflects those discussions.

The Board was asked to note the data at 1.1.1, showing that hard work and focus has driven up accurate reporting of incidents to the National Reporting and Learning System (NRLS); the Trust was only very recently one of the lowest reporters.

Section 1.1.4 of the report shows an increase in incidents of violence and aggression, although it is one of the Trust’s Quality Priorities to reduce both. However, it is possible that this increase is a result of improved reporting. Incidents of restraint have also increased but it is known that if hotspots such as the CAMHS PICU, Eileen Skellern 1 (ES1) and the Place of Safety are removed, it decreases. Therefore, there is a focus on those areas of concern. Both ES1 and the Place of Safety are rated red under QuESTT (Quality, Effectiveness and Safety Trigger Tool) for this reason, as well as having recent changes in management.

Beverley Murphy and Altaf Kara had attended the Reducing Restrictive Practice meeting on ES1 the previous day. The team think that work to improve flow into acute wards has perhaps slowed down the flow of patients out of the female PICU into acute wards and this could be fuelling frustrations and violence.

Lambeth has shown an impressive reduction in prone restraint.

There has been an increase in the use of rapid tranquilisation (RT), and the Board is aware of concerns around physical health checks post-RT. On 24 December, a process change was made to increase oversight of RT, including everyone in the management structure in the review of each instance of its use. This has resulted in better follow-up post-RT, but there is still a hotspot in Eileen Skellern 1.

The Trust is not reaching its targets in terms of collaborative care plans, but there have been improvements within some inpatient wards.

Data on Mental Health Act assessment cancellations and s136 breaches are being watched very closely. If flow issues are properly addressed, these should reduce.

Staff turnover is not moving in the direction the Trust would like. There are resourcing issues around recruitment, which Beverley Murphy is addressing in conjunction with Mary Foulkes.

Overspill to non-NHS beds is now over 60. The Chief Operating Officer is working closely with Service Directors to address this and each borough has developed its own plan.

**Action: Performance and Quality report to the Board to include an update on compliance against Seni’s Law in February 2019**

Matthew Patrick asked what the plan is to eliminate prone restraint entirely. Beverley Murphy referred to the Executive team’s Safety Huddle earlier that week, at which a demonstration was given as to the alternative options to prone restraint e.g. the techniques available to move someone into a seated position. The question was
rightly asked at that Huddle as to why this training is given at all, given the ambition
to significantly reduce restraint; if it is taught, staff will keep doing it. Beverley
Murphy’s view is that there is still restraint in SLaM’s services and if the leadership is
only seen to be critical of restraint, it is likely to drive reporting underground. A QI
project to see if restraint can be reduced to zero (on one ward to begin with) will need
to look at the psychological provision of care alongside estates issues as the
environment is a key factor.

Béatrice Butsana-Sita was pleased to see more statistical process control (SPC)
charts in the report, which makes the presentation of data more consistent and
clearer.

Concern was expressed that the waiting times for CAMHS services are still not
reducing. Rod Booth explained that the initial work went in to addressing the backlog
in Lewisham; the team is doing what it can within its financial envelope, but more
investment is required. Lewisham CCG has responded positively to discussions
about this. Matthew Patrick has also written to the Mayor of Lewisham to alert them
to the issues. A key part of the contract negotiations with commissioners for all
CAMHS services will be the need for additional capacity to address the waiting lists.

Asked about prone restraint on the CAMHS PICU, Beverley Murphy explained that
there is an emerging view that patients tend to put themselves on their fronts when in
distress. This is a relatively new unit and has been incredibly successful, but it is time
for a review now that it has been open for over six months. That review will include
incidents of violence. The team is doing a hard job. Matthew Patrick reflected that a
number of staff have received injuries looking after these very unwell young people.

Anna Walker expressed thanks to those involved for the significant improvements in
this report; the level of engaged discussion at this meeting is a sign of how much
easier it is to read and understand. She did, however, stress the importance of
having data about community performance on a team-by-team basis and asked that
this is delivered at the February Board or the March Quality Committee. She also
noted that the community dashboard does not include caseload data; Rod Booth
explained this information is being validated to ensure accuracy and Beverley
Murphy added that the recent P&Q reviews with each directorate looked
at dashboards for each community team and it is clear that the data needs cleansing. It
is therefore more likely to be ready for March’s Quality Committee.

Anna Walker repeated her request that waiting times are not just reported in terms of
those over twelve months, but also between the target and twelve months. Any wait
over twelve months should be specified in terms of length. Northumberland Tyne and
Wear Foundation Trust measure their waiting times against a target of 18 weeks and
also publish their waiting times. She suggested that SLaM does the same. Matthew
Patrick agreed that waiting times could be put on the website in due course, but they
would need to be published internally first and understood at a service level so that
staff do not feel ill-treated or poorly represented.

**Action:** Future Performance and Quality report to include all waiting times
between target and 12 months, not just over 12 months, and to specify how
long the waits over 12 months are.

Duncan Hames commended management for its openness in sharing data about
CAMHS community waiting times but pointed out that CAMHS in Lewisham is trying
to do meet demand on 24% less funding than Southwark, for example. He attended a
public governing body of Lewisham CCG and flagged this issue.
He also pointed out that 153 children and young people who were reported before Christmas as having waited nine months to be seen were suddenly no longer being reported. Does that mean that they have now been seen, or was the data incorrect? He did not want waits to be over-reported or missed if those people have just been moved to a different ‘queue’.

**Action:** Written response to the apparent anomaly in Lewisham CAMHS waiting time data to be provided to the Board.

**BOD 05/19 LEARNING FROM DEATHS Q2 (15.46)**

Michael Holland summarised that there have been 137 reported deaths since the last quarterly report. The learning is similar to the previous report i.e. the quality of risk assessments and care plans. The suicide reduction plan for the Trust is being reviewed to realign to the zero-suicide strategy. This will be published in April to allow all boroughs to engage.

The Trust’s mortality review policy is being rewritten as new guidance from the Royal College of Psychiatrists means a change in process is necessary.

Duncan Hames asked for more details about the cases behind the statistics. Some of the events are well outside a SLaM care setting. The timing of the reports also vary: some are very recent and therefore the information provided is inevitably inconclusive. He wondered how the Board can make the best use of the information it receives. Beverley Murphy explained that notifications of death are usually distributed within 72 hours, at which point many of the details are unknown. She has proposed that, going forward, the data on the number of deaths is captured in the Performance and Quality report, while the Lessons Learned reports really focus on the themes of learning so that the Board can hold the executive properly to account.

Anna Walker asked to know more about (a) where a death is reported and that person was waiting for a referral to SLaM, and (b) Board-level reviews where there are significant criticisms. She will raise this through Quality Committee.

**BOD 06/19 GUARDIAN OF SAFE WORKING ANNUAL REPORT (15.55)**

Dr Hugh Williams, Guardian of Safe Working, presented the annual report which was taken as read. During the period November 2017 – October 2018, there have been few recruitment vacancies, with the Trust having a near full complement of junior doctors. There are unfilled shifts which are generated for a number of reasons. Of specific focus are the out-of-hours unfilled shifts as these have the biggest impact and typically result in on-call doctors having to act down or cross cover the gaps. These involve Core Training (CT) doctors and have slightly increased over the year.

Areas to address over coming year include improving the on-call experience for Core Trainees (e.g. working facilities) and improving processes for recruiting to known gaps. Dr Williams has spoken to the Core Trainees who would like a more robust process around colleagues calling in sick.

Altas Kara pointed out that the use of locums is reported elsewhere as being an issue, but not in this report. Dr Williams explained that trainees often fill gaps and HR are very proactive in finding solutions. Michael Holland added that a lot of locum costs are for consultants, not junior doctors. Additionally, there have been significant
increases in the cost of locums over the last year, which the South London Partnership is trying to address collaboratively.

Gus Heafield asked what the Trust could do differently to encourage Core Trainees to provide cover. Dr Williams pointed to clearer policies and procedures on booking Core Trainees e.g. using a dedicated Whatsapp group. However, part of the problem is that Core Trainees do resident on-call shifts, so they often cannot provide cover when they are already doing shifts the next day. In the longer term, there will be a review of the Core Trainee rotas.

Roger Paffard reported on a helpful presentation at the Equalities and Workforce Committee about medical workforce staffing and it was agreed that time should be scheduled at the Board to look into it more.

**Action:** Board time to look at medical recruitment and agency challenges to be scheduled.

Geraldine Strathdee thanked, on behalf of the Board, all those willing to step in and fill gaps in rotas for the benefit of the patients.

Mike Franklin expressed concern about doctors working in excess of the EU Working Time Directive; Dr Williams confirmed that they can choose to opt out of the directive if they want to do bank shifts, albeit that choice has not always been systematically captured in the past.

**BOD 07/19 QUALITY IMPROVEMENT PROGRESS REPORT: ICARE (16.07)**

Barbara Grey, Jo Kent and Emily Finch presented an overview of the ICare initiative and an update on the progress made in the key strands of the work to date. ICare is a Trust-wide initiative for improving care and outcomes (ICare) for people using general adult mental health services in SLaM, and to provide sustainable, high quality care in the right place and at the right time. ICare involves the four adult mental health directorates and the focus of the work has been: patient safety; standardised ways of working (care process models for inpatient and community general adult mental health services); and patient flow and capacity. The stated aims are: 10% reduction in readmissions, 35% reduction in length of stay and 50% reduction in violent incidents.

Seven principles have been developed collaboratively that underpin the work. These include (but are not limited to) clear leadership, co-production with service users and carers, and the systematic use of data.

In terms of progress, it has taken longer than anticipated owing to the need to proactively engage staff, service users / carers and stakeholders. Over 200 hundred staff and 40 service users/carers have been involved in the work. There is greater engagement and clarity of the role of ICare within the context of wider Trust improvement work, learning from failures and successes. The reorganisation into directorates from CAGs has had a positive impact with directorate management teams being better placed now to be able to support, lead and help teams focus on their improvement work. There have been some successes at team level and the next twelve months will see a focus on scaling up and spreading successes.

There is a future agenda for integrated care structures which will look different depending on the borough, but it is important to set expectations around standards or care wherever that care is delivered.
Geraldine Strathdee recognised that there is no “quick fix” to make those changes and welcomed the implicit focus throughout on what service users want / need, as well as outcomes. Michael Holland said that a clinical outcomes workshop is being held in the next week, looking at national benchmarking outcomes, and that will be built into the ICare standards.

Béatrice Butsana-Sita asked what the key initiatives are that will make an impact, seeking an assurance that they will actually make headway on creating improvements. Barbara Grey pointed to the Red2Green and Four Steps to Safety initiatives.

The Board discussed the cultural change required to support the improvements. A key question for every person involved, which they should ask themselves every day, is whether this would be good enough for a member of their family. In terms of addressing resistance to change, Barbara Grey had noticed that since each directorate has set up a weekly Safety Huddle, the clear framework and consistency of purpose (at all levels) has helped. The Huddles also allow issues to be tackled quickly and effectively escalated as appropriate.

The Board also discussed the point at which QI programmes of work become policy and there is expectation for the whole Trust to comply. Providing fundamental standards of care, for example, are not optional. At the moment, the QI work is focused on the methodology and in due course resource will be needed to deliver the processes. There is a difficulty in that additional funding will not necessarily buy resource if there aren’t the people out there to recruit. There has to be investment in building a sustainable workforce by making the offer attractive.

Emily Finch and Jo Kent invited any Board member interested in attending the Southwark weekly huddle to do so (maximum of two per week).

**BOD 08/19 CHANGING LIVES WITH SOCIAL CARE (16.30)**

Cath Gormally, former Director of Social Care, and Paul Richards, Head of Social Care in Croydon, attended to present the Social Care strategy, which is closely aligned with the Trust-wide Changing Lives strategy.

The main purpose of the strategy is to ensure that the partnership arrangements between the Trust and local authorities - and the contribution of social care and professional social work in integrated arrangements - are optimised, to help local communities and individuals achieve the best possible outcomes to lead healthy, independent and fulfilled lives. This articulates the important benefits of health and social care integration, working holistically to meet the population health and social care needs of individuals and local communities. It is meant to prevent people being brought in to secondary mental health services where it is better for them not to be there.

It is therefore important that the Trust has a clear strategy to deliver its social care responsibilities where it has statutory duties delegated to it from local authorities under s75 partnership agreements. Similarly, it is important that the Trust has a clear strategy to fulfil its responsibilities as an employer, where it directly employs social workers. The Trust employs c.80 social workers in a variety of roles, but there is currently no formal infrastructure in terms of CPD and registration.

Paul Richards gave an overview of the work in Croydon, where strength-based approaches (looking at people’s own resources and concentrating on what is ‘strong’
rather than what is 'wrong') and having three key types of conversation with a client (about what they want; about what they might need quickly to address a crisis, and what they might need longer term) are being introduced to community mental health teams where the delegated functions for the Care Act sit.

Matthew Patrick felt that this is a terrific piece of work, recognising the challenge in balancing the health and social care agendas and to make progress with such reductions in welfare / social care funding. He asked what the biggest challenge will be to implementing this strategy; Cath Gormally felt that borough leadership will be critical. There should also be a voice of social work throughout the organisation, with social workers supported and properly governed, with the Trust Board having clear oversight of the strategic partnership with social care and the professional issues with directly employed social workers.

Anna Walker asked what the measurable outcomes of this strategy are; Cath Gormally explained that this level of granularity will fall to borough level as one size does not fit all in terms of different communities with different cultures and different needs. Beverley Murphy undertook that the leads for social care in the organisation would come back in a year’s time to set out what progress has been made on a borough-by-borough basis.

**BOD 09/19 FINANCE REPORT & Q3 NHSI REPORT**

Gus Heafield reported that there have been developments since the last report. Work has been undertaken with the Board and with NHSI to revise the forecast and it now looks as though the Trust will break even at the year end, against a control total (CT) target of a surplus of £2m. Not meeting the CT means that the Trust will not receive the last tranche of Provider Sustainability Fund (PSF) monies. Risks to this forecast include two property disposals and the run rate on overspill beds.

In relation to Emergency Department performance, the Trust has been able to secure additional resourcing from commissioners and there has also been very positive feedback from acute trusts, NHSI and commissioners on SLaM’s improved performance over the winter months.

The Finance Team is going through the operational business planning process, the first draft of which is due with NHSI on 12 February. Commissioner allocations for 2019-2020 seem positive in terms of overall growth. The CT that SLaM has been issued with for the next year is also positive, because it recognises the Trust’s underlying deficit.

June Mulroy, on behalf of the Board, commended the Finance team for getting the Trust to this position.

Matthew Patrick felt that it would be useful for the Board to better understand the run rate balance as well as performance against plan.

**Action: February Finance Report to include narrative on the recovery timetable and the run rate, including the metrics that will impact the most.**

Mike Franklin was encouraged that when the Board talks about financial matters, it relates it to the individuals who are impacted by the decisions it makes.

**BOD 10/19 CHIEF EXECUTIVE’S REPORT (17.07)**
Matthew Patrick encouraged people to watch the new Changing Lives film, calling it a “must see”.

The NHS long term plan has been published. It is a key document and it would be helpful to have a board briefing on it and its implications. It is entirely consistent with SLaM’s direction of travel as an organisation and affords an opportunity to quicken the pace of change slightly.

Reflecting on the recent announcement of his retirement, Matthew Patrick thanked staff and stakeholders for their kind words and said that he was happy that he will still be involved in SLaM by virtue of his new part-time role.

**BOD 11/19 COUNCIL OF GOVERNORS’ UPDATE (17.10)**

Jenny Cobley presented the Governors’ report. Governors are sad that Matthew Patrick has decided to retire but are encouraged that they have been engaged in the recruitment process for his successor.

Governors continue to be concerned about bed pressures and are worried that there are patients in the community waiting for a bed. They hope commissioners know that a reduction in bed stock is unlikely. A group of Governors had a good discussion with the NEDs before the Board meeting about commissioning challenges but would like more detail on caseloads and waiting lists. Jenny Cobley asked whether managers are listening to staff on the ground about the issues.

Governors wish the Trust good luck with the imminent return of CQC for the re-inspection.

It has been noted that the Board papers refer a lot to co-production with service users and carers; this approach is very welcome.

**BOD 12/19 BRIEFING ON TRUST PLANNING FOR NO-DEAL BREXIT (17.13)**

Rod Booth reported that an initial meeting was held last week to plan contingencies in the event of a no-deal Brexit. It is understood that the Metropolitan Police Service has cancelled leave in anticipation of civil unrest around 29 March 2019.

Mike Franklin recalled the feelings of discomfort and fear expressed by staff at the time of the 2016 referendum, and asked what reassurance is being given to the workforce. Sally Storey gave an assurance that the Trust has been tracking the impact on staff and has made contact with EU Nationals. The Trust funded the EU settlement scheme on behalf of those affected. There is an issue around spouses of staff who are affected, as there is no data on which staff those are. However, there has been regular communication with staff including direct messages from the Chief Executive.

**Action:** schedule item at February Board on the action taken to reassure staff and update on contingency plans for Brexit / No-Deal Brexit

Altaf Kara recorded feedback from a member of the public gallery that there have already been incidents of difficulties in securing medication.

Duncan Hames felt that the contingency plans should cover any kind of Brexit, not just the possibility of a no-deal Brexit.
BOD 13/19 EQUALITY AND WORKFORCE COMMITTEE UPDATE (17.25)

Roger Paffard recorded in a key risk in the progress being made against the Workforce Race Equality Standard. Mike Franklin noted the disproportionality of BME staff going through disciplinary procedures.

Roger Paffard stressed that the Board needs to be sighted on challenges in medical staffing as at BOD 06/09 above.

BOD 14/19 AUDIT COMMITTEE UPDATE (17.26)

The Board noted the report.

BOD 15/19 FINANCE AND PERFORMANCE COMMITTEE UPDATE (17.26)

The Board noted the report.

BOD 16/19 BUSINESS DEVELOPMENT AND INVESTMENT COMMITTEE UPDATE (17.26)

The Board noted the report.

BOD 17/19 OVERSIGHT AND SCRUTINY GROUP UPDATE (17.20)

The Board noted the report. Geraldine Strathdee that whilst previously the group had been looking at processes for improvement, it was now seeing a good focus on outcomes and implications. This Board had asked if the group could see the trajectory of the plans, including scope for sustainability; from the papers presented at this Board, it is evident that progress is underway, the problems are understood, and it is clear what needs to be done. The pace of improvement is a good news story.

The group has been shown detail for each ward, knowing where they are in terms of performance and what needs to happen next.

Anna Walker stressed the need to find a way to look at themes arising from teams rated amber in the inpatient QuESTT (Quality, Effectiveness and Safety Trigger Tool).

BOD 18/19 REPORT FROM PREVIOUS MONTH’S PART II

The Board noted the report.

BOD 19/19 WRAP UP & NEXT MEETING

The Board noted the draft agenda for the meeting to be held in February 2019.

BOD 20/19 MEETING EVALUATION (17.27)

Beverley Murphy led the meeting evaluation. She noted that the meeting had delivered a consistency of purpose, with a focus on quality. The balance of issues on the agenda meant that the focus of the meeting was mostly about clinical quality. An important thought to always have under consideration is “would this service be good
enough for me or my family?" She felt that there had been a clear commitment to improving the lives of the population.

The meeting had been pushed for time because of good engagement. The QI project presentation before the meeting had justifiably overrun owing to a proper focus on the hard work being undertaken and the positive outcomes.

It was good to hear that data is being used effectively. There were lots of honest reflections and thanks around the table.

The meeting ended at 17.31

The date of the next meeting will be:
26 February 2019, 14.30 – 17.05, ORTUS CENTRE
## Public Board meeting 26 February 2019 – Action points

<table>
<thead>
<tr>
<th>Ref</th>
<th>Issue/Board Paper</th>
<th>Action</th>
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<td>BOD 159/18</td>
<td>Performance and Quality Report</td>
<td>Continue to develop Performance and Quality Report content and format.</td>
<td>KD</td>
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<td>BOD 179/18</td>
<td>Risk Focus: BAF Risk 2 – Operational Delivery</td>
<td>Schedule an item of the development and purpose of the Quality Centre for February 2019’s Board meeting</td>
<td>MH</td>
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<td>BOD 179/18</td>
<td>Risk Focus: BAF Risk 2 – Operational Delivery</td>
<td>Schedule a review of BAF Risk 2 (Operational Delivery), with a focus on care processes, for March’s Board meeting</td>
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<td>March 2019</td>
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<td>BOD 184/18</td>
<td>Chief Executive’s Report</td>
<td>December’s Performance and Quality report to include an update on the Trust’s progress against The Mental Health Units (Use of Force) Act.</td>
<td>KD</td>
<td>December 2018</td>
<td>See BOD 04/19 below; now an action for BM and due in March 2019.</td>
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<td>BOD 194/18</td>
<td>Finance Report</td>
<td>Equalities and Workforce Committee to schedule a discussion about doctor shortages, and mitigations.</td>
<td>MF / SS</td>
<td>March 2019</td>
<td>See BOD 06/19 below. Scheduled for March Board.</td>
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<td>BOD 196/18</td>
<td>Safer Staffing</td>
<td>Present information about multi-disciplinary establishments on inpatient units to the March 2019 Board.</td>
<td>BM</td>
<td>March 2019</td>
<td>Not yet due.</td>
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<td>BOD 198/18</td>
<td>CAMHS Waiting Time Report</td>
<td>Present waiting times data – across all services – to the January Board.</td>
<td>KD</td>
<td>January 2019</td>
<td>A detailed piece of work to review wait times for community services across all boroughs was due to be presented to the Board in due course (TBC). A breakdown for CAMHS waiting times is provided in the February</td>
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<td>Ref</td>
<td>Issue/Board Paper</td>
<td>Action</td>
<td>By</td>
<td>When</td>
<td>Status</td>
<td>RAG</td>
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<td></td>
<td></td>
<td>Performance and Quality report to the Board to include an update on compliance against Seni’s Law in February 2019.</td>
<td>BM</td>
<td>March 2019</td>
<td>See BOD 184/18 above. Will also be taken in depth at May Quality Committee.</td>
<td></td>
</tr>
<tr>
<td>BOD 04/19</td>
<td>Performance and Quality report</td>
<td>Future Performance and Quality report to include all waiting times between target and 12 months, not just over 12 months, and to specify how long the waits over 12 months are.</td>
<td>KD / Rod Booth</td>
<td>TBC</td>
<td>Related to BOD 198/18 above. February’s report includes CAMHS waiting times over 12 months. Awaiting update on other services.</td>
<td></td>
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<tr>
<td>BOD 04/19</td>
<td>Performance and Quality report</td>
<td>Written response to the apparent anomaly in Lewisham CAMHS waiting time data to be provided to the Board.</td>
<td>Rod Booth</td>
<td>TBC</td>
<td>Update awaited</td>
<td></td>
</tr>
<tr>
<td>BOD 04/19</td>
<td>Guardian of Safe Working Annual Report</td>
<td>Board time to look at medical recruitment challenges to be scheduled.</td>
<td>MF / SS</td>
<td>March 2019</td>
<td>Related to BOD 184/18 above. Scheduled for March Board.</td>
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</tr>
<tr>
<td>BOD 09/19</td>
<td>Finance report and Q3 NHSI report</td>
<td>February Finance Report to include narrative on the recovery timetable and the run rate, including the metric that will impact the most.</td>
<td>GH</td>
<td>February 2019</td>
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<tr>
<td>BOD 12/19</td>
<td>Briefing on Trust Planning for No-Deal Brexit</td>
<td>Schedule item at February Board on the action taken to reassure staff and update on contingency plans for Brexit / No-Deal Brexit.</td>
<td>KD</td>
<td>February 2019</td>
<td>On the February Board agenda</td>
<td></td>
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</tbody>
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Key:
- **Green** – completed
- **Amber** – on schedule / not yet due
- **Red** – not on schedule
REPORT TO THE TRUST BOARD: PUBLIC
26 February 2019

<table>
<thead>
<tr>
<th>Title</th>
<th>Service User Story</th>
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<tbody>
<tr>
<td>Directorate</td>
<td>Croydon and BDP</td>
</tr>
<tr>
<td>Presenters attending</td>
<td>Philippa Lalor, Service User</td>
</tr>
<tr>
<td></td>
<td>Rachel Souster, General Manager Inpatient &amp; Crisis, Croydon</td>
</tr>
</tbody>
</table>

Risks / issues for escalation

- BAF Risk 2 Operational delivery structure
- BAF Risk 7 Quality & statutory compliance
- BAF Risk 9 Estates
- BAF Risk 14 Patient flow

The Service User story

‘In need of hospitalisation’, such a big category, a huge chasm of problems, dangers, difficulties. Possibly as varied as a physical acute ward.

It's hard, as me, from the inside to know when I'm in need of that level of help. I can deal with a lot myself. I have intensive support, and most of the time I can verbalise my problems and the solutions needed.

But causing myself serious self-harm, running, screaming, in public, where I collided and bashed my head open, having lost all self-awareness or the ability to speak, caught in a desire to end it, but with a mind so chaotic that I could not, my behaviour, appearance, lack of cognition, speech, descent into bizarre thinking, made me unable to function in the community. Based upon the head injury an ambulance was called, and I went to the A&E Department.

The head injury was superficial, leaving scaring but easily ‘treated’, leaving me in ‘the SLaM room’. Not physically unwell enough to warrant a bed, but mentally unwell enough to ‘join the queue’. I couldn’t disagree to hospitalisation though I did, at times, disagree and try to run out of the emergency department. I was considered able to consent to hospitalisation, although I was also not allowed, by medical staff, to leave.

As an ‘informal’ admission, I joined the bottom of the queue for a bed. That night, on a foam mat on the floor of a Portakabin, used mainly as a porters’ corridor, I did not sleep. When the small side room was not being shaken by laundry cages, beds, trolleys, footsteps, etc., the other half was used as a room to see any other presenting, potentially mentally ill person. Literally, ear to the ground, I heard everything, was shaken by every trolley rolling past, every rattling cage, every shouting porter. The night was cold with a single sheet and I gave up on sleep.

I’d had no medication, and the next day I continued to have no medication, due to it being an A&E Department. I’d had no lunch, no evening meal and, by morning, no breakfast. I would say upon waking, but that night I could not sleep. As A&E is only for 4-6 hours they do not provide meals. The SLaM room, only a stop-gap, again has no access to food. There are sandwiches, but with coeliac disease my body wouldn’t accept that for long.

By 3pm I had a potato, I still had had no medication or sleep. I was still active, chaotic, emotional, and now aware that I was stuck in limbo. I was ‘not priority’ for a bed, and the anticipated waiting time without sleep was going to be ‘a few weeks’. By 4pm psych liaison doctors were trying to work out what to do with me.

A&E has rules on how many hours a patient should wait on a trolley. SLaM has no rules about how many hours/days/weeks a patient must wait on a mat on the floor.
Despite being ‘informal’, I had no money, no house keys, no oyster card, no bank cards, no shoes, no coat (it was February). I had (evidently I don’t remember) been picked up outside, some way from home, without shoes or money or a jumper in February – February 14th, according to records. Whilst I was ‘informal’, letting me walk out of A&E, miles from my house, was not an option. To attempt to track down anything of mine was going to be a mission, due to my inability to remember, but I had my phone, I have a support worker, and she came in to help.

Whilst I was clearly mentally unwell, the day team were faced by the problem that I was neither technically a ‘CUH’ patient nor a ‘SLaM’ patient. Neither – if I chose to leave, or was discharged – could I get home or get into my house. Those I live with were seriously concerned by my mental state, and refused to take responsibility for caring for me in that state.

Yet if I stayed – I had had one jacket potato in 34 hours. I had not slept in 3 days. Before that I had been an inpatient in PRUH having surgery – so nil by mouth for a few days. I had been days without medication after my mental chaos began over a week previously.

In hindsight, we wouldn’t keep an animal in those conditions. No healthy person could experience no sleep, no food and a dramatic change in brain chemistry without feeling that they could not manage another 2 weeks of the same.

I was discharged with intensive home support. Risk of death or no risk, it was the lesser of the two evils. I was driven home by my support worker, when someone was in at home. They were not happy that I was home …. but with nowhere to go, there was no other humane choice. My housemate was shocked and terrified. As someone who knows me well, she has seen me deteriorate, seen me becoming less able to talk, to know what is going on around me, or to think in any rational way, complete any basic task or be aware of basic dangers. For her, due to go away for the weekend, the idea of leaving someone at home alone whom she has previously driven to hospital, who suddenly cannot speak clearly, will not be able to find food themselves, will not notice normal dangers of a hot stove, is terrifying and unimaginable. She cannot cancel work, but is terrified to leave, afraid as to what she may find when she returns.

I guess I’m ‘lucky’. I was too ill, too confused, too sleep deprived, too chaotic to kill myself. With support, I didn’t have to leave the house and my meds were kept by someone else, having been collected by prescription. Banks were called and cards reissued. The psych liaison team did everything they could. I was stuck in a bureaucratic black hole and their hands were tied. I think you’ve guessed – I was lucky, I survived. At least Croydon Council had been paying the care agency ….

What we did well
The Psych Liaison Team worked in a responsive and caring way.

What we did not do well
The conditions of the stay, length of wait, and lack of suitable food were not acceptable.

What we will do now
- Overall experience: the learning from this story helps us to be aware of all the elements that contribute to the patient experience in A+E. Some progress has been made and we will keep working to improve.
- Environment: Croydon University Hospital opened a new A+E facility in December 2018, with dedicated mental health assessment rooms which provides a better environment while at A+E short-term.
- Length of wait: We have enhanced the Home Treatment Team to include dedicated staff to assess anyone in A+E who is identified for informal admission.
- Length of wait: We have introduced dedicated beds at the Bethlem Hospital to try to ensure there is always a bed available for people who may need an informal admission, as well as working to address barriers to discharge earlier in the patient’s stay to improve overall availability of beds.
- Food: Croydon A+E does offer specialised food choices for people waiting. We will revisit with staff what is available and how to escalate if they are not getting what the patient needs.
REPORT TO THE TRUST BOARD: PUBLIC
26 February 2019

Title | Developing the next King’s Health Partners 5-year Plan
--- | ---
Author | Jill Lockett – KHP Director, Performance & Delivery
Accountable Director | Dr Matthew Patrick – SLaM NHS FT Chief Executive Officer

Purpose of the paper
The attached cover note and slide deck review the King’s Health Partners 5-year plan, 2014 – 2019 Improving Health and Wellbeing, Locally and Globally, and asks for comments and directions for the new 5-year plan from the South London and Maudsley NHS FT Board both on the strategic themes and the engagement with staff groups going forward.

Executive summary
The King’s Health Partners Academic Health Science Centre (AHSC) 5-year plan completes in March 2019. The AHSC is likely to be asked by the Department of Health to submit for re-accreditation toward the end of 2019. The attached slide deck reviews some of the achievements, opportunities, challenges and weaknesses of the Academic Health Sciences Centre and suggests areas for further review and discussion in the development of the next King’s Health Partners 5-year plan.

Throughout February, the KHP Executive will meet with and hear from the four founding partners of the Academic Health Sciences Centre about the areas of priority and focus going forward. Following some initial conversations with the King’s College London Health Faculties Executive, plans are underway to test this further across the Health Schools and University governance structure in February and March. Based on these NHS and University conversations a listening exercise with wider stakeholders and system partners will begin.

The KHP Joint Boards have concluded that “The top-level ambition for King’s Health Partners is to provide sustainable, impactful innovation across the partners and beyond”

To develop our strategy, we need to agree how best to fulfil this ambition. Our suggested criteria for testing future priorities and options for the 5-year plan should be as follows:

Criteria for testing our future priorities:
- Be of value to the KHP partners themselves and be beyond what any one partner can achieve alone;
- Contributes to developing a skilled workforce for now and in the future
- Ideally be something that we are uniquely positioned to do better than others;
- Contribute towards a sustainable partnership and system;
- Be of value to improving population health, locally and globally

Partner Executive teams and Boards are asked to:
- note and comment on the potential timeline for AHSC re accreditation - slide 2;
- review and comment on the high-level messages regarding KHP’s progress to date -slides 4 - 16;
- discuss the potential to ensure the strong connection between your organisational strategy and the new 5 Year plan for King’s Health Partners, and for this to help resolve the weaknesses described on slide 17;
- consider and comment on the criteria set out on slide 18 for determining future priorities and the early draft themes set out on slide 19;
- suggest mechanisms and names for wider staff and stakeholder engagement so that the AHSC team can hear wider views and connect the work of the AHSC to local staff and teams - slide 20

**Risks / issues for escalation**

The process and timeline for AHSC re-accreditation are not yet clear. Whilst the development and maturity of the AHSC strategic partnership does not directly affect the clinical, operational and financial performance of the Trust, the benefits of partnership in attracting workforce, commercial partnerships, health system partnerships and research investment are potentially significant.

**Committees where this item has been considered**

<table>
<thead>
<tr>
<th>Date</th>
<th>Committee / Meeting</th>
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<tbody>
<tr>
<td>13 February 2019</td>
<td>SLaM NHS FT Senior Leaders group</td>
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</table>
KHP Reaccreditation and 5-year strategy development

KHP engagement discussions - February 2019

1. Purpose

This note and attached slide deck set out the materials and considerations to support the development of the next KHP 5 Year Plan 2019 – 2024 and any reaccreditation response requested by NIHR in 2019. Comments and directions are welcome from partner Executive Team and Boards ahead of a wider stakeholder listening exercise going forward.

2. Developing our next 5-Year Plan

The King’s Health Partners 5-year strategy; “Improving Health and Wellbeing, Locally and Globally” completes in March 2019. The changing landscape for the NHS and University sector; the new NHS Long term Plan, the Industry and Life Sciences strategy, the Accelerated Access Review, challenges in recruitment and retention of our workforce, and developments in health education and research provide a strong platform for a new five year plan for the King’s Health Partners Academic Health Sciences Centre.

The NIHR licence for the 6 AHSCs in England was due to expire in March 2019 and has been extended to December 2019. It is anticipated, but not yet clear or confirmed, that NIHR may launch a third round of AHSC accreditation at some point in 2019.

The KHP Joint Boards propose that a new KHP 5 year plan be developed in consultation with the founding partners of the AHSC, local teams and the wider system in order to develop a framework for future focus to add further strength to the partnership and local health system.

3. Preparing for Partner Board & Executive Conversations

Throughout February, the KHP Executive will meet with and hear from the four founding partners of the Academic Health Sciences Centre about the areas of priority and focus going forward. Following some initial conversations with the King’s College London Health Faculties Executive, plans are underway to test this further across the Health Schools and University governance structure in February and March. Based on these NHS and University conversations a listening exercise with wider stakeholders and system partners will begin.

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o Contribute towards a sustainable partnership and system;
o Be of value to improving population health, locally and globally

4. Conclusion

Partner Executive teams and Boards are asked to:

o note and comment on the potential timeline for AHSC re accreditation - slide 2;
o review and comment on the high-level messages regarding KHP’s progress to date - slides 4 - 16;
o discuss the potential to ensure the strong connection between your organisational strategy and the new 5 Year plan for King’s Health Partners, and for this to help resolve the weaknesses described on slide 17;
o consider and comment on the criteria set out on slide 18 for determining future priorities and the early draft themes set out on slide 19;
o suggest mechanisms and names for wider staff and stakeholder engagement so that the AHSC team can hear wider views and connect the work of the AHSC to local staff and teams - slide 20

Professor Sir Robert Lechler
Jill Lockett
King’s Health Partners
11 February 2019
Developing our 5 year plan

King’s Health Partners
February 2019
Partner Executive Team and Board engagement
Context – reaccreditation expectations and timings

- Academic Health Sciences Centres are coming to the end of the second accreditation cycle (2014-2019).
- In October 2017, the Department of Health asked the six AHSCs to provide feedback on the AHSC model and the value of accreditation.
- In spring 2018, the current accreditation period was extended from March 2019 to December 2019.
- We are anticipating that there will be an indication in spring 2019 as to the next steps for applying to be an accredited Academic Health Sciences Centre. In the October 2017 submission and subsequently, King’s Health Partners has argued that this should be accompanied by some central funding.
- We have started the thinking about the strategy for King’s Health Partners for the next five years (2019-24) in anticipation of an invitation to apply for reaccreditation.
- The timeframes within which to respond could be quite short, hence commencing the strategy development process to enable wide engagement and input.
Clinical academic context – setting the scene for planning the next five years

1. The biomedical revolution
   • ‘omics explosion
   • Gene editing
   • Digital, machine learning, and technology
   • Immunotherapy and advanced therapeutics
   • Regenerative medicine
   • Neuroscience and Mental Health

2. Opportunities linked to Life Sciences Industrial Strategy

3. Emerging system leadership opportunity to address health sustainability challenges


5. Opportunities created by large scale population data to address needs of local population, and enable improvement and transformation.

6. Need to develop workforce, including new roles and skills to deliver new models of care integrated with research, and to be an attractive major employer locally and worldwide

7. Uncertainty created by British exit from the European Union.
Clinical academic assets and competitive position

• Three foundation trusts with broad coverage as well as specialist
• Strong mental health theme - 1st in world mental health research at IoPPN
• Health-heavy university in top 20 in world
• Excellence in neuroscience, mental health, cardiovascular, haematology, immunity/inflammation, advanced therapies, imaging sciences
• Emerging strength in cancer, respiratory, healthcare engineering research, child health
• Launch of the Comprehensive Cancer Center, development of the ACN
• Mind & Body programme
• Uniquely broad range of health education
• Institute and CAG model integrating clinical, research and education
• Value-based healthcare programmes including launch of London Medical Imaging and AI Centre for Value Based Healthcare,
A world-class clinical academic structure

Excellence in healthcare delivery
- Comprehensive portfolio of excellent quality local and regional services
- International recognition: oncology, neurosciences, mental health, cardiovascular, fetal medicine, children’s health, renal and liver disease, dermatology, haematology

Excellence in health research
- One of top six biomedical research universities in UK (REF 2014)
- Five MRC Centres, three NIHR Research Centres and other Centres of Excellence
- IoPPN and SLaM globally leading neuroscience research centre
- Founding Partner of Crick Institute

Excellence in health innovation
- At the forefront of innovation and exploiting new technologies including advanced therapies, biomedical engineering, imaging, digital health
- Capacity building for end-to-end translational research integrated across specialist and community care settings
Transformation through translational research

Advanced Therapies
£10m Advanced Therapies Centre plus £20m in-kind from GSK
£5m Connecting Capabilities in Advanced Therapies (cross-London)
£20m Celgene partnership signed in Haematology
Spinouts Gammadetla Therapeutics & Leucid Bio; MultiPeptide licensed to UCB

Training & Institutional Support
AstraZeneca Global Pharmaceutical Development Clinical Science Fellowships and Training Initiative (Cancer)
MRC Fellowships programmes x3 : Strategic Skills, Data Science, “Productivity”; ESRC Fellowships Programme
MRC PhD top-ups x3 for industry partnership, “productivity” and data science (above)
MRC Confidence in Concept £1m

Global Health
£7m NIHR Global Health Hub
£13m RCUK “Growing Capabilities” Hubs x2
£2m NIHR Global Health Research Group (stroke)
£5m Wellcome Trust “Our Planet, Our Health” (with Imperial)

Mental Health & Neurosciences
£15m Dementia Research Institute Centre
€55m EU-AIMS: Innovative Medicines Initiative consortium in autism

Appointments/Awards
4 new Fellows of the Academy of Medical Sciences: Professors Louise Arsenault, Frank Kelly, Giovanna Lombardi and Catherine Williamson
3 new NIHR Senior Investigators: Professors Steve Williams, Rob Stewart and Andrew Pickles

Health Data
£7m Health Data Research UK “substantive site” (cross-London); £1.5m MRC Mental Health Data Pathfinder
£1m MRC Fellowships Programme (Data Science) and PhD studentships (AI and Data Science)
£4m East London Genes & Health (with QMUL) award from Wellcome Trust
£7.5m for cross-London consortium for Local Health and Care Record Exemplars
Transformation through experimental medicine infrastructure

Medical Imaging & Biomedical Engineering:
- 7T, 3T MRI, X/MR
- PET, PET/MR and cyclotron
- New programme in surgical science

Child Health/Life course:
- Dedicated paediatric Clinical Research Facility
- Centre for the Developing Brain
- TwinsUK cohort

Clinical Trials Office:
- Largest commercial and non-commercial provider of clinical trials three years running

Clinical Trials Unit:
- Design, conduct and analysis support
- >20 experimental medicine studies
- Leads the national NIHR Statistics Network

Experimental Medicine Hub:
- Guy’s and St Thomas’ Biomedical Research Centre
- Advanced Therapies Centre
- GMP Cell Therapy
- Immune profiling platform + single cell functional genomics
- Phase 1-accredited Clinical Research Facility

Gene Therapies Manufacturing:
- Producing more lentiviral vectors for clinical trials than the rest of Europe put together

Mental Health and Neuroscience:
- South London and Maudsley Biomedical Research Centre
- Mental health/neurology-focused Clinical Research Facility
- Dementia Research Institute Centre
- Centre for Translational Informatics
Transformation through education

- NIHR Integrated Academic Training programme, unique in London
- 100 resources and more than 11,500 registered users on the King’s Health Partners Learning Hub
- New MBBS Curriculum 2020 focused on developing a workforce trained to deliver holistic care
- Education Academy coordinating CAG educational progress
- New PGCert in Advanced Medical Training aimed at international learners
Our CAGs remain the collaborative vehicles through which our tripartite mission for excellence in care, research and education is delivered.

This year we have grown from 21 to 22 CAGs, with the introduction of a Palliative Care CAG.

16 out of 22 CAGs have published their Outcomes Book.

All have published their Impact stories.

They continue to be the place where the NHS and University front line connects.
Progress - Institutes and Networks

Institute & Network development:

- Strong leadership commitment from across the partners
- All programme directors and institute executives in place
- Strong strategic vision and delivery plan for 2018/19
- KHP won competitive process for Operational Delivery Networks in neurosciences, cardiovascular, and children
- Informatics, Mind and Body, and Value Based Healthcare flavour beginning
- King’s Health Partners branding to come through lead brand hierarchy in institute branding going forward
Progress - network engagement

**KHP Cardiovascular – Institute & Network**

- Local: Transformation in organisation and delivery of simple and complex cardiovascular services, leading to step-change in quality and outcomes.
  
  *Example: Heart failure*

- Regional: King’s Health Partners system leadership for specialist cardiovascular services in NHS South catchment.
  
  *Example: Vascular surgery*

**Institutes & networks – reaching a wider population and supporting health outcomes**

- Full range of 24/7 complex services at hub
- Medium-size / small spokes: simpler in-patient services, pre- and post-op assessments / follow-up, diagnostics (multi-disciplinary teams, specialist nurses)
- Similar high standards of care for entire population regardless of geography
- Clinical scale surpassing other centres
- Equal access to complex procedures and emerging innovations for all patients
- Embedding research in an entire network with large population research base
Progress in - Value Based Healthcare

- Increasing interest in value based healthcare locally
- More focus on outcomes within national policy
- Financial position of NHS
- Population health outcomes for England do not compare favourably to other comparable countries

- Delivering population health models for Institutes & Networks
- Development of Integrated Care Systems
- Local adoption of value based healthcare as a strategy for improvement and/or commissioning
- Partnerships locally, nationally, and internationally

- Capability to measure and share outcomes and costs to make value-based decisions – continue pathway pilots
- Complete the seven remaining outcomes books
- Develop outcomes scorecard approach
- Vital 5, including for mental health, children, and old age
- Increasing influence and delivery securing external funding
Progress in - Mind & Body

In a system with lots of moving parts and shifting agendas, the Programme must remain agile and responsive to clinical needs and local priorities

- Significant focus from national regulators which can support our work
  - IAPT-LTC expansion
  - Promotion of integrated ‘extensivist’ models
  - Improving physical health of those with SMI

- Local agendas & opportunities to collaborate
  - Local Care Network development as building blocks of local Integrated Care System
  - Lambeth and Southwark cross-organisational alliances (Lambeth Living Well Network Alliance & Southwark Together)

- Opportunities to be at the frontier of research – e.g. immuno-psychiatry – and lead the way in understanding its impact on clinical practice
Progress in - Informatics

➢ Substantial opportunities to exploit advances in IT and informatics to improve outcomes for patients, enhance patient experience, empower patients through information and wearables, transform delivery of care, advance research and bring forward new treatments including personalised medicine, enable new forms of commissioning and system planning

➢ Local partner strategies, including EHR replacement
➢ One team across Institutes and Networks
➢ South East London STP, Health Innovation Network South London
➢ Local Health and Care Record Exemplar, Health Data Research UK, Digital Innovation Hubs, AI and Imaging
➢ National policy – significant focus on digital health

➢ Potential to scale up innovation from within King’s Health Partners – CogStack, IMPARTS, HealthLocker, Lambeth DataNet
➢ Delivery through London partnerships
➢ Further national competitions and sources of funding
➢ Commercial opportunities and collaborations
Progress in - Global Health

- Substantial opportunities to develop improved research, education and clinical systems in developing regions.
- Significant learning from the Sierra Leone, Somaliland and The Congo
- GSTT Zambia programme – potential for learning and roll out

- Masters in Global health continues to thrive and create pipeline of volunteers and staff
- Volunteer numbers increasing but rarely from KHP and NHS locally

- Significant increase in University wide research grants, many connected to NHS clinical academic teams locally – Mental Health, Cancer, Women and Children, Infectious Disease
Collective clinical academic strengths on which we can build

- 2 BRCs
- Unparalleled facilities for experimental medicine
- Rich pipeline of advanced therapeutics
- Expanding portfolio of industry partnerships
- An enabling estate across all 3 major campuses
- Nationally and internationally leading clinical outcomes integrated with research in highly specialist services
- Potentially leading role in STP, in wider specialist service configuration, and in network development
- Growth and increasing education and training reach
- Emerging strength in healthcare engineering
- Developments across Centre for Translational Informatics
- Engagement with the living laboratory of SE London
- Emerging strength in population health/global health
Challenges & weaknesses to address through strategy?

Challenges to be addressed through an integrated clinical academic mission

- Translating innovation into improving outcomes at scale for patient and population – the future role of CAGs
- Integrated clinical academic workforce - training and skills, recruitment, global challenges, pace and affordability
- Distressed finances, health & university, education & training commissioning agenda - Complexity, resource to deliver, pace of delivery, expertise
- Integrated IT systems: integration of IT and informatics remains a critical step in the development and delivery of one team working
- Pace and scale of programme implementation and roll out

Local weaknesses & challenges to be resolved going forward

- Range of delivery capability, buy-in and focus across 22 CAGs - connection to host partner strategies – alignment with KHP future plan
- Pace, purpose and scope of 5 KHP Institutes – internal and external opportunities and challenges
- Organisational bandwidth and cognitive burden on range and scale of KHP and partner programmes
Developing our priorities for the next five years – *for discussion*

To test and develop with partner executive teams and boards:

The KHP Joint Boards concluded that "The top level ambition for King’s Health Partners is to provide *sustainable, impactful innovation across the partners and beyond*”

When considering the themes for the new strategy we think the following 5 criteria should be applied:

- Be of value to the KHP partners themselves and be beyond what any one partner can achieve alone;
- Contributes to developing a skilled workforce for now and in the future;
- Ideally be something that we are uniquely positioned to do better than others;
- Contribute towards a sustainable partnership and system;
- Be of value to improving population health, locally and globally.
Delivering our ambition: strategy 2019-24
Early thoughts on key themes – for your comments please

High-impact innovation
- Novel diagnostics
- Therapeutics
- Devices
- Digital technologies

Service Redesign for Better Outcomes
- Mind & Body
- Value Based Healthcare
- Healthcare engineering
- Education and training

Population health gain
- Locally and globally
- Improving outcomes
- Reducing inequalities
- Population health data for direct care and research
- Global health

Enablers:
- Clinical Academic Groups
- Institutes and One Team
- Alliances and collaborations
- Industry partnerships
- Health Innovation Network, and other AHSNs and AHSCs
- KHP Education Academy
- KHP Learning Hub
- KHP Informatics (e.g., including CTI)
- BRCs and CRFs
- Systems leadership – through CCGs and STPs

Strategic context
Including:
- Partner strategies (e.g., KCL Vision 2029; e.g., GSTT Patients, People, Partnerships; e.g., SLaM Alliance partnerships; e.g., KCH strategy development)
- Wider partnerships and collaborations (e.g., Local Care Networks; e.g., South London Partnership; e.g., S&LSP)
- Industrial Life Sciences Strategy
- NHS 10 Year Plan priorities
- Our Healthier South East London STP
- One London (LHCRE)
- Health Data Research UK
- Accelerated Access Review
- EU relationship
Engaging staff and stakeholders in developing our strategy – *for discussion*

- The development of the strategy for the next five years is an opportunity to hear and benefit from experience and expertise both within our partnership and across our local system.

- To support this we envisage holding a series of listening exercises through late winter and early spring, framed by the strategic themes.

- We do not know the timings of any reaccreditation process, but see this as important preparation to support an accreditation application.

- An opportunity exists to use dates held in March, and to plan further dates in April and early May, following discussions with Partner executive teams and boards in February.

- We would value advice on who to involve, where, and how from within partner organisations to engage as widely as possible.
Questions & discussion

Executive Teams and Boards are asked to:

• note and comment on the potential timeline for AHSC re accreditation - slide 2

• review and comment on the high-level messages regarding KHP’s progress to date - slides 4 - 15

• discuss the potential to ensure the strong connection between your organisational strategy and the new 5 Year plan for King’s Health Partners, and for this to help address some of the weaknesses described on slide 17

• consider and comment on the criteria set out on slide 18 for determining future priorities and the early draft themes set out on slide 19

• suggest mechanisms and names for inclusion in further staff and stakeholder engagement – slide 20
# REPORT TO THE TRUST BOARD: PUBLIC

26th February 2019

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<tr>
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| Accountable Director | Bruce Clarke – CAMHS Clinical Director  
|                     | Trudi Seneviratne – CAMHS Clinical Psychiatrist |

## Purpose of the paper

For the Board to note this Annual Report from the Director of Public Health in Croydon and to explore what its findings might mean for SLaM and to agree next steps.
WE ARE CROYDON
EARLY EXPERIENCES LAST A LIFE TIME
The first 1000 days from conception to the age of 2

DIRECTOR OF PUBLIC HEALTH ANNUAL REPORT — 2018
I am delighted to provide my introduction to Rachel Flowers’ third Annual Public Health Report for Croydon. All Directors of Public Health are required to produce an independent annual report on the health of their population, highlighting key issues that impact on the population.

Rachel and I have been working together over the last few years looking at how we can best address the historic inequalities here in Croydon. This report is a strong statement and provides a range of recommendations at a time when we have competing priorities and not enough resource. It comes, however, at the right moment, when we are focusing on prevention and increased locality working.

The first 1000 days of a child’s life lay the foundations for their own and Croydon’s futures. In last year’s report Rachel highlighted that there are stark health inequalities between communities just a 30 minute bus ride apart. In this report she will be showing what this means for early childhood and what opportunities there are to make a difference and to reduce these health inequalities.

The more we understand about the first 1000 days and what influences them at borough, community, locality, family and individual level, the more chance children in Croydon will have, to thrive equally.

Croydon Council is committed to working with all our communities and partners, to put prevention at the heart of all our work. Although we will not see some of the impacts of our work for 10 years or more, we know that early experiences last a lifetime!
INTRODUCTION BY RACHEL FLOWERS
DIRECTOR OF PUBLIC HEALTH

Within Croydon we are starting to embrace a prevention model, working with communities at a locality level to reduce the likelihood or impact of a range of issues.

Over the last few years evidence from across the world and all communities, has been demonstrating the importance of the first 1000 days - the period from conception to when the child reaches the age of 2. These first 1000 days for a child are fundamentally important because they lay the foundations for the rest of their lives. A healthy start in life gives each child an equal chance to thrive and grow into an adult who makes a positive contribution to the community.

Children born into secure and loving families, where their physical and emotional needs are met, are more likely to grow up to be better educated, more financially secure, and healthier - emotionally, mentally and physically. They are more likely to give their own children the same good start in life and are less likely to be involved in acts of violence, either as the perpetrator or victim or misuse substances.

It is well accepted that inequalities result in poor health, social, educational and economic outcomes across the whole of the life course and across generations. Many people do not appreciate how much of a person’s brain development is completed by the age of 2, well before most people are able to remember. By focusing this report on the first 1000 days we can identify the opportunities we have to make a difference to lives of parents and babies and narrow the inequalities gap.

This report will reflect on the role that the wider environment, the socio-economic situation of families and the issues such as age, ethnic group, disability and sexual orientation, play in the first 1000 days of a child.

I will also talk about Adverse Childhood Experiences. These are experiences that impact negatively on later childhood. Indeed, work undertaken by colleagues from Croydon’s Safeguarding Children’s Board has identified how many of the young people impacted by knife crime and youth violence have experienced Adverse Childhood Experiences. Evidence shows that children who experience stressful and poor quality childhoods are more likely to: develop health-harming and anti-social behaviours, perform poorly in school, be involved in crime and are ultimately less likely to be a productive member of society. Although not all Adverse Childhood Experiences will occur within the first 1000 days, I feel they are important to emphasise in my report, because of evidence showing that people who experience four or more ACEs in their childhood are, for example, 14 times more likely to be involved in violence.
My report proposes three principles to guide our future actions:

- **Know your role:** We all have a role to play in helping children thrive during the first 1000 days—however we need to understand what this role is and how best we can contribute through a whole systems approach.

- **Health in all policies:** All partners should shift the focus from managing the burden of ill health to promoting actions that create the right conditions for good health by a health in all policies approach.

- **Breaking the inequalities cycle:** Tackling the socio-economic determinants of health—e.g. job, homes, social cohesion, education, income—is key in reducing the inequalities in early years that become the inequalities in health and life chances. We all have a role to play in reducing these inequalities.

Nearly 6000 children are born in Croydon each year. With each one of these children we have an ‘unparalleled opportunity’ to shape ‘the brains of the children who will build the future’ (1). This report makes recommendations for action over the next year, which I believe will start having a significant impact not only on the children under 2 now but for the rest of their lives.

While there are recommendations throughout the report, there are four that I would like to highlight here:

1. **Review, revise and join up the maternal mental health pathways from the community, and primary care, through midwifery and health visiting and other partners by 2019.**

2. **All (100%) of midwives and health visitors in Croydon to receive training around recognising and supporting families with risk of multiple Adverse Childhood Experiences by the end of 2019.**

3. **A 1000 front line staff in the council, NHS, police and voluntary sector to have training around Adverse Childhood Experiences, their causes and impact, in 2019.**

4. **Develop and Implement a plan of action for increasing the levels of awareness about pre pregnancy health and the importance of preparing for pregnancy by the end of 2019.**

I would like to thank the Croydon Youth Congress for their help in shaping some of the messages in this report. They represent Croydon’s future.
All children’s first 1000 days are influenced by their parents’ or carers’ worlds and the environment these provide.\(^2\)

These worlds are shaped by a diverse range of social, economic and environmental factors including household income, homes, educational attainment, health, relationships, community networks, pollution and neighbourhoods.\(^3\)\(^4\)\(^5\) Together these factors are known as the wider determinants of health and it has been estimated that they account for between 40% and 50% of differences in health.\(^5\)

Due to the importance of these wider determinants in shaping the first 1000 days and in perpetuating inequalities, I have included evidence of their impact throughout the report. The icons on the image opposite will appear on each page as a reminder.

Individual characteristics such as age, ethnicity and disability will also influence the first 1000 days. The age of parents when they have their children can affect pregnancy and child outcomes; both young and older women may experience poorer outcomes.\(^6\) In 2015, 174 children in Croydon were born to mothers under 20 and 297 were born to mothers over the age of 40.\(^7\)

Croydon is a diverse Borough. For example, 45% of births in 2016/2017 were to mothers from black, asian and minority ethnic (BAME) groups.\(^8\) This diversity impacts the first 1000 days. Mothers from ethnic minority groups are, for example, more likely to breastfeed their babies\(^9\) and BAME groups are at greater risk from diseases such as sickle cell and diabetes, both of which can affect pregnancy outcomes.\(^10\)\(^11\)

Croydon is also home to a wide range of cultures and languages, whose role and influence needs to be understood. Records show that in 2015, 3503 births in Croydon were to mothers not born in the UK\(^12\). Apart from possible difficulties relating to language and culture, women who have recently arrived in the country may lack social support;\(^13\) and those who are asylum seekers or refugees may have experienced trauma.\(^14\)
Parents’ and carers, experiences of poverty, homelessness, social isolation, discrimination, poor housing, as well as their relationships and experiences, can affect their child’s development and physical and mental health. For example, higher levels of stress and depression are experienced by people who live in deprived communities and parents’ stress and depression can affect the first 1000 days of children’s lives.

Impacts of inequalities

- Young mothers (under 25 years old) living in low income households and/or deprived areas are more likely to have a baby born with a low birth weight.
- There is a higher infant mortality rate among Pakistani, Black Caribbean and Black African groups.
- Mothers with higher socioeconomic status are more likely to set a regular bed time and read to their child. These mothers experience lower levels of postnatal depression.
- Evidence shows that safe public spaces, with pavements to walk on and lighting, are part of the physical infrastructure that helps people to maintain social connections. These factors cut across the whole of the life course as part of sustainable communities and places in which people are born, grow, live, work and age.

The wider social and economic factors are a key source of inequalities. They result in poorer health and worse social, educational and economic outcomes across the whole of the life course and for many, the cycle will continue into future generations. It is only by addressing inequalities from before birth and supporting children and their families, that we can break the cycle and help children achieve their potential.

The fact that in England today people from different socio-economic groups experience avoidable differences in health, well-being and length of life is, quite simply, unfair and unjust.

Definition

Health inequalities are ‘Avoidable and unfair differences in health status between groups of people or communities’.

Adapted from Feinstein et al. 2004
CHAPTER 1
PARENTS AND CARERS WORLDS: THE SETTING FOR THE FIRST 1000 DAYS

What do we know about the economic circumstances of people and children in Croydon?

Some areas in Croydon are amongst the 10% most deprived in the country. We know that in 2015, almost a fifth (18.7%) of Croydon children were living in poverty.\(^8\) This means that over 1100 of the nearly 6000 babies born each year in Croydon may have their first 1000 days touched by the effects of poverty. Child poverty varies significantly across the Borough. For example almost four times as many children live in poverty in Fieldway (30%) than Sanderstead (8%).

What do we know about health inequalities in Croydon?

Girls born in some areas of Croydon are expected to live six years more than their counterparts in other areas and for boys, the difference is over 9 years. There is also a difference in how long people can expect to live in a healthy state. As an example, women in Old Coulsdon are expected to live at least nine years longer in a healthy state than women in Broad Green.\(^{23}\)
In my introduction, I mentioned Adverse Childhood Experience (ACEs). There is a danger that some experiences during the first 1000 days will turn into ACEs with long lasting impacts, into adolescence and beyond. I would like to reflect briefly here that whilst ACEs are present throughout all sections of society, children living in poverty or in disadvantaged areas are both more likely to be exposed to ACEs such as homelessness and neglect, and are more likely to experience a ‘cluster’ of them. I will talk about ACEs, their sources and long term impact on children later in the report.

The relationship between parents’ and carers’ social and economic circumstances, their own physical and mental health and that of their children, shows how vitally important it is for us all to understand the wider needs and circumstances of each family and their community. With this understanding, action and support can be offered, by the right people, at the right time, in the right place.

It may seem that circumstances such as income, housing and educational level cannot be easily changed, yet there is considerable evidence about the many ways in which communities, families, individuals and statutory and voluntary services can work together to ensure that all children have the opportunity to experience the best possible first 1000 days.

Focusing this report on the first 1000 days provides us with an opportunity to direct our collective attention to making an even greater difference to the lives of parents and babies in Croydon and on narrowing the inequalities gap.

Adverse childhood experiences and the wider determinants of health

Adapted from: Ellis and Dietz, 2017

Wider Determinants

Adapted from: Ellis and Dietz, 2017

PRE PREGNANCY

DAY 1

DAY 1000

Page 51 of 271
The setting for the first 1000 days

Examples of what we are doing in Croydon

- Gateway and Welfare Services are providing a pathway to financial stability, improved housing options and employment support through initiatives such as Community Connect: The Food Stop and food poverty reduction schemes
- Croydon Council is a London Living Wage employer and through the Croydon Good Employer Charter is encouraging other employers in Croydon to sign up too
- We are making better homes available to Croydon residents (via our Brick by Brick programme)
- Through the community Safety Strategy we are focusing on violent crime and antisocial behaviour and particularly on improving the safety of children and young people

Recommendations

1. Ensure training raises awareness among staff of the importance of the first 1000 days and pre pregnancy health, the impact of wider determinants such as poverty and how they can make a difference in their role for children and their families
2. Use population and community level intelligence at borough and locality level to target resources and services to those individuals and communities most in need
There is a large and growing body of evidence that good health before pregnancy provides the best start for children. Planning pregnancy, looking after our health and getting support when needed, are all aspects of preparing for pregnancy.

Many parents will have pre-existing health and social needs, some of which may be complex. Whilst it is never too late to start to address these needs, the optimum time to identify and manage them, is before pregnancy.

One way my annual report can contribute to improving the first 1000 days and reducing inequalities is to highlight what being healthy before pregnancy means.

To begin with, DID YOU KNOW that few of us actually know what being healthy for pregnancy means? Lack of awareness of the importance of pre-pregnancy health may result in parents not making changes to their health behaviours, or not seeking the support that would have positive benefits.

DID YOU KNOW that it is not just the mother’s pre-pregnancy health that is important? A father’s health also has an impact on the long term health of a child.
And it is not just the health of the present day parents which is important. DID YOU KNOW that what parents themselves experienced in their own first 1000 days and earlier can be passed onto their children? This leads to cycles of poor health across generations which together we need to break.

The good news is that there are things we can all do to improve health before pregnancy. Planning for pregnancy is an important step but DID YOU KNOW that only two thirds of us clearly plan a pregnancy? (31) DID YOU KNOW that planned pregnancies are less risky? Planned pregnancies result in fewer premature births, fewer babies born with low birth weights, and greater involvement from fathers once the child is born. (35) Planning between pregnancies is also very important; a gap of 18-59 months between babies is safer for mother and baby. (37) The period between pregnancies is an ideal time to try and resolve any issues that may affect the first 1000 days of the next baby. (13)

Taking the national rates we have estimated that each year approximately 2000 babies will be born where the pregnancy was unplanned. Women with recent experiences of smoking, drug use, and depression are more likely to report an unplanned pregnancy. (38) Only just over half (55%) of teenage mothers say they had planned their pregnancy. (38) Teenage parents are more likely to have a baby with low birth weight and are almost two thirds (64%) more likely to bring up their child in poverty. (39) There is much that we do in Croydon to support this group.

**EVIDENCE**

**Impact of the father’s health on a child**

- A father who smokes increases the risk of congenital heart defects, cancers, brain tumours and leukaemia in their children. (32)
- A father’s BMI is associated with their child’s BMI and body fat. (33)

**Pre pregnancy health awareness**

- Women rarely tell health professionals that they are planning to become pregnant. (31)
- Most future parents do not make changes to prepare for pregnancy and only start considering it once pregnant. (31)
- Health professionals have been found to have a lack of knowledge about pre pregnancy health, but also they report a lack of demand from patients for advice on pre pregnancy care. (30)
- Where people had received advice from health professionals, they were more likely to make changes to their behaviour before pregnancy. (30)

**What do we know about unplanned pregnancy in Croydon?**

Taking the national rates we have estimated that each year approximately 2000 babies will be born where the pregnancy was unplanned. Women with recent experiences of smoking, drug use, and depression are more likely to report an unplanned pregnancy. (38)

Only just over half (55%) of teenage mothers say they had planned their pregnancy. (38) Teenage parents are more likely to have a baby with low birth weight and are almost two thirds (64%) more likely to bring up their child in poverty. (39) There is much that we do in Croydon to support this group.

“You read up on all the stuff about being healthy during a pregnancy, but nothing really before that. It never occurred to me, we just started trying and a few months later, it happened.” (13)
Early Experiences Last a Lifetime

CHAPTER 2
HEALTH BEFORE PREGNANCY, PLANNING PREGNANCY AND TEENAGE PARENTS

EVIDENCE

Unplanned pregnancies have

- A 31% increased risk of the baby being delivered before 37 weeks, known as premature birth.\(^{(35)}\)
- A 36% increased risk of being born with a low birth weight.\(^{(35)}\)
  This has important consequences for the development of the child which are explored later.
- Fathers of unplanned pregnancies are less likely to live with the mother and less likely to be involved in caregiving and play.\(^{(36)}\)

What do we know about teenage parents in Croydon?

It is very positive that the number of teenagers becoming pregnant in Croydon has reduced, as it has nationally. There were 175 teenage (under 18) conceptions in 2016 compared to 262 in 2010 although this is still high compared to London and England.\(^{(8)}\) There were 36 predicted births to teenagers under the age of 18 and 153 to teenagers aged 19 and under in 2018.\(^{(38)}\)

EVIDENCE

Teenage pregnancy

- Low birth weight is increased by 30%.
- Still birth is increased by 24%.
- Infant mortality is increased by 75%.
- 21% of teenagers not in education, employment or training are teenage parents.
- Teenage parents have the highest rate of poor mental health up to 3 years after birth.\(^{(39)}\)
- Teenage parents are three times more likely to smoke throughout pregnancy, with 28% smoking compared to 7.5% of over 25s.\(^{(41)}\)

Young parents

Some examples of what we are doing in Croydon

- The Croydon Healthy Schools programme and Croydon Youth Engagement Team provide programmes focusing on mental and physical health for vulnerable young parents.
- Croydon’s Young People’s Sexual Health outreach team is working with schools and in places where young people congregate.
- The ‘Be Sex Safe’ section on the Just Be website hosts a range of self-help tools and resources to promote healthy relationships.
- Young first time mothers (age 19 and under at conception) are supported by the Family Nurse Partnership through pregnancy and early childhood to maximise their own, and their child’s, potential.

Recommendations

3. Provide senior strategic support from across the partnership to the borough’s teenage pregnancy action plan and ensure that its work is widely understood and linked to other strategies and programmes.

4. Increase awareness among young people of all sexes of the importance of being healthy before pregnancy and planning pregnancies through implementation of the teenage pregnancy action plan and maximising the opportunities created by the statutory changes both in SRE (sex and relationship) education and in PSHE (personal, social, health and economic) education.

5. Ensure the findings of Croydon’s Vulnerable Adolescent Mental Health deep dive are acted upon to identify when, where and how to provide support to children and teenagers.

VOICE OF CROYDON’S FUTURE:
‘Make sure you are ready for pregnancy’
N, age 13
Women are increasingly entering pregnancy with more health problems. Long term health conditions such as diabetes, sickle, cell severe asthma, heart disease, high blood pressure, epilepsy and psychiatric conditions can effect pregnancy and women with long term conditions should all see a doctor before planning to become pregnant.

Almost two thirds of women who died in the UK between 2013 and 2015 in pregnancy had pre-existing physical or mental health problems. Some women are at greater risk of having a long term health condition. Type 2 diabetes is, for example, more common in South Asian, Black Caribbean and Middle Eastern women. Sickle cell and thalassaemia are more common in women of black ethnicity and these conditions increase the risk of premature labour and problems with growth of the baby. Diabetes in pregnancy is becoming more common as more women are overweight or obese and are older when becoming pregnant.

DID YOU KNOW that an estimated one in four women have a health condition that would benefit from pre-pregnancy counselling? A study found that these women were no more likely to seek or receive specific pregnancy advice.

What do we know about pre-existing health conditions in Croydon?

Using national data, we have estimated that 1500 or more babies born in Croydon each year have a mother with a pre-existing health condition.

Knowledge about pre-pregnancy health and pregnancy planning

Some examples of what we are doing in Croydon

- Live well and Just Be are signposting and supporting people around ‘Be Sex Safe,’ ‘Be Active’, ‘Be Alcohol Aware’, ‘Be Food Smart’, ‘Be Smoke Free’ and ‘Be Happy’
- We are delivering a partnership led Borough wide healthy weight action plan

Recommendations

6. All agencies to maximise opportunities to raise awareness of the importance for both parents of planning for pregnancy and addressing health issues before becoming pregnant.

7. Use existing and new media to promote pre-pregnancy health messages, particularly about smoking and being overweight or obese for people living and working in Croydon.
There are things we can do to prepare for pregnancy which will positively improve a child’s first 1000 days.

Smoking, weight, diet, alcohol and drug use can all affect a pregnancy. These are all what is known as ‘modifiable behaviours’ that is they are things that we can change.

**DID YOU KNOW** that stopping smoking in pregnancy avoids the greatest risk to birth outcomes? Babies in the womb need oxygen to grow and smoking not only reduces the oxygen in the mother’s blood, it can also restrict the growth of the baby and is a cause of low birthweights.

Although stopping smoking is a positive action at any point, it is better to stop smoking before becoming pregnant. Women who receive counselling prior to pregnancy are three times more likely to quit smoking before conceiving than those that don’t.

Smoking is more common in certain groups. Asian and Pakistani women have much lower smoking rates than women of White ethnicity, and people living in the most deprived areas are more likely to smoke and less likely to quit.

**DID YOU KNOW** it is not just maternal smoking that affects babies? Babies with a father who smokes also have a higher risk of a low weight at birth AND children who grow up in households where there are smokers are at increased risk of sudden infant death and are more likely to have respiratory problems.

**What do we know about smoking in Croydon?**

Although overall, 12% of adults in Croydon smoke, pregnant women report lower rates. In 2016/2017 6.6% of women in Croydon reported smoking at the time they gave birth, which means that about 353 babies were born to mothers who smoked. More will be born in households that smoke. We also know that across Croydon there are areas with higher rates of smoking for example, in Fieldway and New Addington (see map on page 17).

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**Examples of what we are doing in Croydon**

- **We provide one to one support to women who are pregnant or postnatal to help them stop smoking with Livewell Croydon**
- **Everyone can access stop smoking tools, advice and support on our website.**
- **All Croydon foster carers are required to have smokefree homes**

**Recommendations**

8. Develop a pathway for pregnant smokers and their partners into smoking cessation support that is opt out rather than opt in

9. Identify the groups continuing to smoke through pregnancy and review the evidence base to identify the best approaches for helping them to stop smoking

10. Develop a smoke free homes programme with social and private landlords
Smoking
Smoking is associated with an increased risk of:

- Miscarriage by over 30% and still birth by nearly 50% [51]
- Low birth weight and reduced growth [46] [48] [52]
- Childhood asthma [53] [54]
- Obesity in childhood [54] [55]. There is nearly twice the risk of being overweight as a teenager [56] and up to four times the risk of being overweight as an adult [57] [58]

% of people on GP register listed as a current smoker QOF (2016/17)
The numbers of overweight and obese adults is a high profile national issue with 59% of adults in England being overweight and obese with an estimated annual cost to the NHS of £6.1 billion.

“UK MOST OVERWEIGHT COUNTRY IN WESTERN EUROPE”
says OECD 2017

**DID YOU KNOW** that over 40% of women in England are overweight, and more than one in five are obese at the start of pregnancy?

Although overweight and obesity is an issue for the country as a whole, some parents and groups are more at risk. For instance, 46% of black women are overweight or obese compared to 39% of White and Asian women.

Environments can help us maintain a healthy weight but we know that the environment in Croydon varies across the borough. For example, there are more fast food outlets in Fairfield than Kenley (see map on page 19); some areas have greater access to green spaces, and walking is easier and safer in some neighbourhoods than others.

Due to the complex web of issues underpinning the current epidemic of overweight and obesity, our collective efforts are required to reduce its influence over the first 1000 days of children in Croydon.

**IMPACT OF INEQUALITIES**

**Overweight, obesity and underweight**

- 38% of women living in the most deprived areas are overweight at the start of pregnancy compared to 29% in the least deprived

- Women over 40 are more likely (40%) to be overweight or obese at the start of pregnancy

- 11% of young mothers (under 18 years) are underweight at the start of their pregnancy
Fast food outlets (as at December 2017) Rate per 100,000 population
Overweight and obesity in either the father or mother can affect pregnancy. For example, a mother who is overweight has four times the risk of developing diabetes in pregnancy compared to mothers who are a healthy weight.\(^{(63)}\) It also affects the long term health of their child.\(^{(65)}\)

**DID YOU KNOW** that children whose parents are a healthy weight, are less likely to be overweight or develop type 2 diabetes?\(^{(34)}\) \(^{(54)}\)

### EVIDENCE

**Obesity during pregnancy:**

- Doubles the risk of caesarean section
- Triples the risk of pre-eclampsia (a condition of high blood pressure in pregnancy which can be dangerous for mother and baby)
- Increases the risk of premature delivery by 30% and antenatal and postnatal depression by 33% \(^{(63)}\)

**A child whose mother is overweight or obese prior to pregnancy:**

- Is more likely to be obese in childhood \(^{(54)}\) and grow up to be obese in adulthood \(^{(65)}\)
- Has a higher risk of type 2 diabetes and high blood pressure \(^{(34)}\)
- Has a 30% increased risk of asthma and wheeze \(^{(65)}\)

### What do we know about overweight and obesity in Croydon?

59% of adults in Croydon were classified as overweight and obese in 2016/2017.\(^{(66)}\) We have estimated from the national rates that nearly half of the 6000 babies born in Croydon this year will have mothers who are overweight or obese. This has important health implications for mothers and children and is a source of potential long term health inequalities.

“If I’d known the impact of carrying all this extra weight when I was pregnant….. then I might have tried to lose weight before. They didn’t tell me”.\(^{(13)}\)

**VOICE OF CROYDON’S FUTURE:**

What is important for the first 1000 days?

Not smoking, eating bad foods, drugs, overexercising, not to get too stressed

Z, age 13

PRE PREGNANCY

DAY 1

DAY 1000
Diet and nutrition before pregnancy can also have long term impacts. For example, taking folic acid before pregnancy prevents babies having severe problems with the formation of their spine and nerves. Women living in the least deprived areas are more likely to take folic acid.

What do we know about folic acid in Croydon?

Using the national rates we have estimated that 1200 babies each year in Croydon have mothers who did not take folic acid before pregnancy.

POTENTIAL IMPACTS OF INEQUALITIES

Folic acid

- 20% of white women take folic acid before pregnancy compared to 12% of black women and 13% of Asian women
- 10% of women aged 20-24 don’t take folic acid compared to 25% of women aged over 45
- 10% of women living in the most deprived areas take folic acid compared to 26% of least deprived

DID YOU KNOW that a baby’s development in the womb is dependent not just on the mother’s diet during pregnancy, but also on the stored nutrients and fats from through her lifetime. So although it is important to eat well during pregnancy, it is also important to eat well before pregnancy.

The long term implications of our own health as parents on our children’s health is a recurring theme in this report. A baby girl is born with all the eggs for her own children and the quality of these eggs will reflect her mother’s health; a mother’s nutritional state can even affect her grandchildren’s health! A new baby in Croydon therefore represents past, present and future health which is another key reason for this focus on health before pregnancy and the first 1000 days.
Pregnancy is a hugely exciting and positive time for most families and their babies.

Good mental and physical health during pregnancy provide the best possible support for the babies first 1000 days and beyond. Parents’ mental, emotional and physical health, their relationships, their weight, their diet and their drug, alcohol and tobacco use can all affect a baby’s brain and physical development.

A key message is how important pregnancy is for babies’ developing brains. Brain development starts just after conception and continues at a rapid pace through the first years of life; when our brains grow the fastest.

**DID YOU KNOW** that experiences during pregnancy can change a baby’s brain? Although it is genes that predict babies early brain development, their early experiences will shape it. These experiences can affect how genes are switched on, or whether they are switched on at all. This can lead to genetic changes by a process called epigenetics and these changes can pass down through the generations. These changes have both physical and mental causes.

Good mental health during pregnancy helps provide the positive conditions every baby needs.

**DID YOU KNOW** that as many as one in four women experience mental health problems during pregnancy and the first year after birth?

Supporting parents’ mental health is important because untreated antenatal depression and depressive symptoms can affect brain and child development, and lead to behavioural problems during adolescence.
A woman who smokes while pregnant induces epigenetic changes in three generations at once: in herself, her unborn child and her child’s reproductive cells.

Source: Jude Huffon, Harvard Magazine, 2017

Receiving the right support and treatment can help improve a mother’s mental health and ensure a child’s development is not affected. Positive relationships and social support during pregnancy are beneficial.

Although poor mental health during pregnancy can be experienced by anyone, some women are more at risk. This includes women without good social support, women who have experienced domestic violence or previous abuse, women living in deprived areas, and women with a history of mental health problems.

It is not only a mother’s mental health that is important. DID YOU KNOW that the father’s mental health can also affect children in early life? 1 in 10 fathers will develop depression after the birth of their baby.

When this effects the relationship between parents, or results in hostile or detached parenting from the father, this can lead to problems with child and adolescent emotional and behavioural development.

EVIDENCE

Effects of depression

- Women with depression are likely to have a shorter duration of breastfeeding. Children are more likely to have behavioural problems and poor social emotional development even into adolescence.
- Maternal anxiety during pregnancy has been shown to change the brain structure and function in offspring in infancy up to late adolescence.
- Maternal suicide is the leading cause of death in the postnatal period.

Numbers of women who experience anxiety and depression during pregnancy

- More than 10% of women experience issues with mood during pregnancy.
- 3.3% of pregnant women will experience major depression.
- 17% of teenage parents will experience major depression.

EVIDENCE

Effects of depression

- Women with depression are likely to have a shorter duration of breastfeeding. Children are more likely to have behavioural problems and poor social emotional development even into adolescence.
- Maternal anxiety during pregnancy has been shown to change the brain structure and function in offspring in infancy up to late adolescence.
- Maternal suicide is the leading cause of death in the postnatal period.

Numbers of women who experience anxiety and depression during pregnancy

- More than 10% of women experience issues with mood during pregnancy.
- 3.3% of pregnant women will experience major depression.
- 17% of teenage parents will experience major depression.

Impact of Inequalities

Depression

- Social determinants are an important cause of depression in pregnant women and mothers.
- Up to 26% of pregnant women in poor, urban communities have depression.
- Women from minority ethnic backgrounds are more likely to live in deprived environments and therefore may be at higher risk of depression in pregnancy.
What do we know about the mental health of parents in Croydon?

In 2015/2016 it was estimated that between 525 and 1600 women in Croydon during the perinatal period had a mild to moderate depressive illness anxiety or adjustment disorders.\(^{(22)}\)

Supportive relationships and social support during pregnancy have positive effects on outcomes. Unfortunately not all women have a positive relationship and some women lack social support; migrant women, especially asylum seekers and refugees, are vulnerable to being socially isolated and a study has shown that they are at higher risk of having a premature birth or mental health problems.\(^{(14)}\) This may also be related to past traumatic experiences, challenges with accessing health care before and during pregnancy and other social circumstances such as poverty.\(^{(14)}\)

**EVIDENCE**

**Supportive relationships and social support**

- Mothers in supportive relationships are more likely to be physically active during pregnancy \(^{(89)}\) and have smaller risks of pregnancy complications such as infections \(^{(88)}\).
- Women without social support are more likely to develop symptoms of depression during pregnancy \(^{(72)}\).
- After delivery, social support is associated with better breastfeeding, maternal self-esteem and adapting to care for the baby \(^{(90)}\).

**Mental health in pregnancy and beyond**

**Examples of what we are doing in Croydon**

- Croydon has a strong community perinatal mental health team
- Specialist delivery of the Live Well Croydon programme by Mind
- Our new partnership Early Help offer working in local communities will ensure the needs for vulnerable families with young children are provided for

**Recommendations:**

14. Review, revise and join up the maternal mental health pathways from the community, and primary care, through midwifery and health visiting and other partners by 2019.

15. Ensure all staff have the skills to identify parents and prospective parents with potential mental health concerns and are able to support and signpost them appropriately

16. Ensure that all programmes that promote pre-pregnancy health (see previous recommendation box) address mental health concerns before pregnancy

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**DEFINITION BOX**

**Perinatal period**

The perinatal period commences at 22 completed weeks (154 days) of pregnancy and ends seven completed days after birth.\(^{(88)}\)
What do we know about the potential for lack of social support in Croydon?

Some parents are more likely to lack social support and this includes lone parents, those living in temporary accommodation and asylum seekers. In 2014 447 babies in Croydon (7.9% of births) were registered by just one parent.(31) This is one sign that there may be parents in Croydon who lack social support. Another is the number of children or expected children living in temporary accommodation. In March 2018 there were 864 Croydon children or expected children living in temporary accommodation.

Relationships which cause stress, anxiety and trauma can negatively affect the unborn child.(76) A key source of stress is domestic abuse.

DID YOU KNOW that domestic abuse is likely to start or escalate during pregnancy?(70)

Women experiencing abuse may find it difficult to access antenatal care and there are risks to the child including low birth weight.(70) Disabled women are twice as likely to suffer physical abuse from their partner than non-disabled women and are likely to be particularly vulnerable to pregnancy abuse.(91)

What do we know about domestic abuse in Croydon?

Based on national figures, we have estimated that between 240 and 540 babies are born each year to mothers who may have experienced domestic violence during pregnancy.

EVIDENCE

Domestic abuse
Possible consequences of domestic abuse include:
• Mothers who may find it difficult to access antenatal care
• An increased risk of premature birth
• An increased risk of low birth weight
• Poorer development of the foetus and the child (70, 92)

EVIDENCE

Who experiences domestic abuse?
• It is estimated that 7.4% of women and 4.8% of men experience domestic abuse each year
• It is estimated that between 4% and 9% of women experience domestic abuse during pregnancy (92)
• Young women, those with long term disability or mental health problems and who are pregnant or have recently given birth are particularly at risk (93)

Excess stress during pregnancy can have long lasting effects on the baby and on through to adulthood. Babies who experience higher stress in the womb are more likely to have emotional, behavioural and learning problems later in life. (94) (95) (96)

Source: Cruceanu et al, 2017, Current Opinion in Behavioural Sciences (97)
What do we know about stress affecting women and their families in Croydon?

We know that depression and anxiety, financial insecurity, unplanned pregnancy, lack of support and domestic violence are all potential sources of stress and that some women will experience more than one of these sources of stress. We have estimated that at least 1000 of the 6000 babies born each year in Croydon are at higher risk from stress during pregnancy.

Effects of excess stress during pregnancy

- Different hormones can cross the placenta making the child more reactive to stress and threat themselves
- Children may have longer-term problems with emotional and cognitive functioning (Thompson, 2014) and an increased risk of behavioural problems (98)

Relationships, social support and excess stress during pregnancy

Examples of what we are doing in Croydon

- A multi-agency vulnerable women’s group identifies pregnant women who need additional support
- The Family Justice Centre is available to all women in insecure and unhealthy relationships who experience domestic violence
- Our partnership Early Help offer prioritises working with children and their families where there is domestic abuse
- Homestart runs a support group for asylum seeking women in hostel accommodation from 6 weeks before babies are born until 6 weeks afterwards
- We are implementing a borough wide approach to prevention and early intervention that will strengthen community based knowledge and support and through the partnership Early Help offer we will support people at the right time and in the right place

Recommendations

17. Review the effectiveness of the current arrangements for identifying women who need more social support and make recommendations to address any system wide gaps that are identified

18. All (100%) of midwives and health visitors in Croydon to receive training around recognising and supporting families with risk of multiple Adverse Childhood Experiences by the end of 2019

19. 1000 front line staff in the council, NHS, police and voluntary sector to have training around Adverse Childhood Experiences, their causes and impact in 2019
GOOD PHYSICAL HEALTH

Good physical health during pregnancy contributes to creating the best possible environment for the first 1000 days.

Being overweight or underweight, smoking, drinking alcohol and using drugs during pregnancy have long term impacts on children.\(^\text{(64) (99)}\)

The impacts of overweight and obesity and smoking were discussed earlier, here I would like to touch on the effects of drinking alcohol, drug misuse, diet and exercise.

DID YOU KNOW that even mild to moderate alcohol consumption especially during the first three months can cause changes in brain development, and cause behavioural problems in childhood?\(^\text{(100) (101)}\)

Drinking more than one unit a day in pregnancy increases the possibility of pre term birth and low birth weight.\(^\text{(102)}\) Children’s height, behaviour, fine motor skills, cognitive development and mental health can be changed by drinking alcohol during pregnancy.\(^\text{(99) (102)}\)

Nationally 1% of women declare that they consume alcohol during pregnancy although actual levels of drinking during pregnancy are thought to be higher.\(^\text{(49)}\) There is evidence that 3% of children under the age of one live with a harmful drinker and 9% live with a hazardous drinker.\(^\text{(104)}\)

What do we know about drinking in pregnancy in Croydon?

Using the national rate of 1% we have estimated that 60 of the 6000 babies born each year will have mothers who drink. We have also estimated that about 700 children under one live in households where there is harmful or hazardous drinking.\(^\text{(104)}\)

DID YOU KNOW that even mild to moderate alcohol consumption during pregnancy can increase the possibility of low birth weight,\(^\text{(107) (108)}\) premature birth and perinatal and cot death?\(^\text{(108)}\)

Drugs taken later in pregnancy can effect growth, cause intoxication or withdrawal symptoms.\(^\text{(73)}\)

What do we know about drug use during pregnancy in Croydon?

Using the national rates we estimate that 300 of the 6000 babies born each year will be born to mothers who took drugs during pregnancy and over 400 infants will be living with a drug taking parent.
It is vital that women eat well during pregnancy.\(^{(109)}\) When babies in the womb have to adapt to insufficient nutrients it can lead to permanent changes which may be the origins of diseases in later life such as coronary heart disease, diabetes, stroke and hypertension.\(^{(110)}\)

However, “eating for two” should also be avoided.\(^{(111)}\) No increased food intake is needed in the first six months of pregnancy and only an extra 200 calories per day for the third trimester.\(^{(112)}\)

Aside from folic acid, there are other vitamins and minerals important for pregnancy. Some people, for example, may need to take more vitamin D. A deficiency in iron in pregnancy can harm the development of the child and a supplement may be advised if women are not getting enough from their diet.\(^{(113)}\) Other important nutrients in pregnancy include vitamin C and calcium, which can be obtained through a balanced diet.\(^{(114)}\)

Along with good nutrition, being physically active can help women maintain a healthy weight throughout pregnancy. Women should aim for 150 minutes of moderate intensity exercise per week.\(^{(115)}\)

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**Evidence**

**Physical activity in pregnancy:**

- Helps control weight gain
- Helps to reduce high blood pressure problems
- Makes it 30% less likely women will develop gestational diabetes\(^{(116)}\)
- Improves fitness
- Improves sleep
- Improves mood\(^{(115)}\)
Accessing timely and good quality antenatal care, including scans, immunisations and examinations, physical and mental health advice and support, is a key component of supporting parents through pregnancy.

**IMPACT OF INEQUALITIES**

**Antenatal care**

- Women in low income households are 60% less likely to have had any antenatal care in pregnancy. (118)
- 28% of black women and women of ‘other’ ethnicity attended their first pregnancy appointment after 13 weeks compared to 15% of women of white ethnicity. (48)
- 77.3% of women with the highest level of deprivation had their first antenatal appointment within 13 weeks compared to 86.7% of the least deprived women. (49)

**DID YOU KNOW** that some women are less likely to have antenatal care or access care later than recommended? (49) (118)

Women should have their first antenatal appointment within the first 13 weeks of pregnancy and ideally by 10 weeks. (119) Some women are more likely to attend later in their pregnancy putting themselves and their child at extra risk, for example women aged between 18 and 24 and women living in more deprived households. (49)

Immunisations in pregnancy are important for both the mother and child are an easy and effective way of preventing certain illnesses.

**DID YOU KNOW** only 45% of (pregnant) women in England had the flu vaccine in 2016/17? (120)

Pregnant women are recommended to have the seasonal flu vaccine because they are more likely to develop serious illness. (121) One in 11 maternal deaths between 2009-2012 was a result of flu. (82) Pregnant women are also advised to have the whooping cough (pertussis) vaccination between 20 and 32 weeks, or until labour, to help protect the baby from whooping cough in their first few weeks of life. (122)
LOW BIRTH WEIGHT

Reducing the number of babies born with a low birth weight will improve child health and development and long term health.\(^{(55)}\)\(^{(55)}\)

Some women are at higher risk of having a baby with a low birth rate, for example women who smoke or have unplanned pregnancies.\(^{(35)}\)\(^{(46)}\)

What do we know about the numbers of babies with a low birth weight in Croydon?

In 2016 158 babies born after 37 weeks had a low birth weight. 445 of all babies in 2016 (7.7%) were born with a low birth weight and of these 73 were born with a very low birth weight.\(^{(7)}\) The map shows that the percentage of babies born with a low birth of weight varies across the Borough and is more common in deprived areas.

Definition

Pre term birth and low birth weight
- Pre term is defined as being born before 37 weeks.\(^{(123)}\)
- A low birthweight baby weighs less than 2500g (5lb 8oz) and a very low birth weight is below 1,500g (3lb 8oz).\(^{(7)}\)

EVIDENCE

Factors effecting birth weights
- Low birth weights are more common in women of black ethnicity and women with higher levels of deprivation.\(^{(49)}\)
- Babies whose mothers are aged under 20 years have around a 20% higher risk of low birthweight; this can be partly explained by the higher than average smoking rates in pregnancy.\(^{(49)}\)
- Maternal smoking is associated with a birth weight reduction of around 250g.\(^{(46)}\) Paternal smoking is also linked to low birth weights\(^{(46)}\) as is maternal passive smoking.\(^{(49)}\)
- Unplanned pregnancy increases the possibility of low birth weight by 36% and pre term birth by 31%.\(^{(35)}\)
- Drinking more than one unit of alcohol per day\(^{(102)}\), taking cannabis, cocaine and opioids\(^{(108)}\) and experiencing domestic abuse also increase the risk of having a baby with a low birth weight.\(^{(70)}\)

Impacts of low birth weights
- Low birth weight is associated with worse child health, even up to 11 years of age.\(^{(35)}\)
- Low birth weight babies are twice as likely to have problems with cognitive development or need specialist support in school and are also more likely to have physical problems such as asthma and high blood pressure and high cholesterol in adulthood.\(^{(29)}\)
% of Live births at term with low birth weight 2001-2015

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The first two years of life are a time of great opportunity for children, their families and the wider community. (2)

The rate of brain development during the first two years of life is extraordinary with more than 1 million new neural connections formed every second but it does not all happen on its own. While we are all born with many billions of brain cells, they need help connecting with each other. (2)

DID YOU KNOW that stimulating environments and positive relationships encourage the development of these connections? (2) Talking, love, a hug, engaging, playing, reading, singing all help form the connections. (1)

Positive, warm and predictable social relationships with parents, carers, the extended family, the community, child care providers, are all of vital importance to young children’s brain development. (2) (5) (74) (94) (126)

Section of a stimulated brain
Section of an unstimulated brain

How children’s brains develop during the first 1000 days lays the foundations for future educational success, income and health. (3) (76) Without positive brain stimulation there is less development, and getting a child back on track later requires significant effort and cost. (75)

The strength of the early influences on the brain means that the first 1000 days are a time of great opportunity but also great vulnerability for children. (126)

A study of 19 000 babies born between September 2000 and September 2002 reported that behaviours and characteristics from early childhood affected children’s performance six to ten years later. (55)

The one and two year development checks undertaken by the health visitors provide an early opportunity to a child’s progress and whether they and their family may need some extra support. Children who attend day care will also have progress checks with, for example their nursery or childminder.

An important and nationally available measure of a child’s social, emotional and cognitive development is school readiness. Not all children are equally ready for school; nationally, girls have a higher level of school readiness than boys and pupils that are eligible for free school meals are 20% less likely to be school ready. (127)

EVIDENCE

Impact of positive relationships and stimulation on child development

- Children with good parent child relationships in the first year are more likely to develop stronger cognitive skills and progress better at school. (13)
- Children whose parents do not think stimulation is important have significantly more difficulties. (55)
- Higher parent/child closeness is associated with higher verbal ability and more pro-social behaviours such as helping and sharing. (128)

IMPACT OF INEQUALITIES

Child development

- By the age of three, disadvantaged children are almost a year and a half behind, on average, in their early language development. (129)
- On average 40% of the overall gap between disadvantaged 16 year olds and their peers has emerged by the age of five. (130)
- At the ages of five, seven and eleven, single parenthood is associated with lower test scores. (55)
- Low maternal education has a negative impact on all cognitive outcomes at 5, 7 and 11. (55)

VOICE OF CROYDON’S FUTURE:

Help children to stimulate their brain through music, puzzles, trying to talk with them.
What do we know about school readiness in Croydon?

In Croydon in 2016/2017, 73.4% of all children achieved a good level of development at the end of reception, however only 62.8% of children receiving free school meals achieved a good level of development.(7) While both these percentages have improved significantly since 2012, and compare well to London and England averages,(7) if the current trends continue, 1500 of the 6000 babies born in Croydon this year may not be ready for school.

The majority of children will have safe nurturing environments which foster good child development. When, however, the child’s immediate environment is a source of stress it can have long lasting negative effects.(76) Learning to cope with adverse situations is a normal part of child development but continuous high levels of stress may cause a child to experience what is called “toxic” or “chronic stress”. Chronic stress can lead to physical and chemical disruptions in the brain that can last a lifetime and affect learning capacity, physical and mental health.(76)

A relationship with a supportive adult can block the effects of stress and therefore some children will be impacted less than others by adverse circumstances.(132)

Chronic stress can be caused by extreme poverty, abuse, neglect, maternal withdrawal, caregiver substance misuse or parental mental health issues. (76) (132) (134)
Early excess stress can also affect future generations. **DID YOU KNOW** that problems experienced in childhood can pass on to future generations due to lasting genetic changes?⁹⁴ This means that we need to take every opportunity we can to support families and children and increase the chance of breaking the cycle.

**DEVELOPMENTAL EFFECTS**

Maternal stress during pregnancy affects the developing fetal stress systems

Critical periods of brain development are influenced by stress

Severe, chronic stress can result in a lower threshold for stress response

Source: Short, Derek 2016 [135]

**Positive environments, child development and stress in infancy**

**Examples of what we are doing in Croydon**

- Croydon’s partnership Early Help offer delivers a range of evidence based programmes including parent support
- Parents are informed about activities and support through Best Start antenatal welcome evenings and through social media
- Improvements are being made to parks and recreational spaces to increase opportunities for play

**Recommendations**

20. Ensure maximum delivery of the health visiting development checks, from the antenatal visit to the 2 year check
21. Ensure all parents who may need additional support know what options are on offer and where to access them.
22. All practitioners working with children and families understand what toxic stress is, its sources and what impact it may have
Physiological health needs in infancy

Immunisations, screening, breastfeeding, healthy diet, being active, being safe, good oral hygiene all contribute to a healthy start in life.\(^{(70)}\)

The national childhood immunisation programme is offered to every child. Immunisation is a proven and cost effective way of eliminating damaging and life threatening infectious diseases.\(^{(20)}\)

Children who have not received all their immunisations are more likely to be admitted to hospital by nine months.\(^{(136)}\)

What do we know about immunisation rates in Croydon?

Croydon is doing much worse than nationally. Taking MMR (Measles, mumps and rubella) as an example, the Croydon MMR vaccination rate in 2017/2018 for two doses by age five (required for full coverage) was 67%, which is considerably lower than the national average of 87.2% (still far lower than the recommended 95%) and is no higher than the rate was five years ago.\(^{(8)}\) There is a similar picture for the other childhood immunisations.\(^{(8)}\) If we apply the current MMR percentage to the 6000 babies born in Croydon this year, we estimate that over 1500 babies will not receive two MMR doses by age 5 and other vaccines leaving them vulnerable to infections that can have very serious complications. Croydon had a number of measles cases during the outbreak in 2018.

Potential impacts of inequalities

Uptake of immunisations

Children are less likely to be fully immunised if they:
• Are from a minority ethnic background
• Are from a disadvantaged ward
• Are from a larger family
• Have a single parent or teenage parents
• Have a mother who smoked in pregnancy\(^{(136)}\)

Immunisation rates

Examples of what we are doing in Croydon

• An active Health Protection Forum (HPF) meets regularly to scrutinise immunisations and other health protection issues. Croydon is one of few areas to have such a forum
• Croydon Council obtained funding for a research project with the national behavioural insights team to understand the barriers to MMR uptake with Croydon

Recommendations

23. All GP practices to reach 95% of MMR immunisations
24. Implement comprehensive vaccination for vulnerable groups

We hear a lot about breastfeeding BUT DID YOU KNOW that breastfed babies are less likely to be overweight and obese or have type 2 diabetes?\(^{(137)}\) Breastfeeding also helps bonding between mothers and their babies.\(^{(138)}\) The cost to the NHS every year of treating just five types of illnesses linked to babies who were not breastfed is at least £48 million.\(^{(139)}\)

The UK government recommends exclusive breastfeeding for around six months.\(^{(140)}\) In England 74% of mothers start to breastfeed, with 44% breastfeeding at 6 weeks and only 1% exclusively breastfeeding until 6 months.\(^{(141)}\)

Older mothers and some ethnic groups are much more likely to breastfeed whereas young, white mothers working in routine and manual jobs and who left education early are least likely to breastfeed.\(^{(140)}\) Health inequalities experienced by mothers and children in low-income families would be reduced if babies were breastfed exclusively for the first six months.\(^{(140)}\)
What do we know about breastfeeding rates in Croydon?

The number of babies who were breastfed at birth in 2016/2017 was 84%. Local data from the health visiting service shows that between January and March 2018 72% of babies (where breastfeeding status was known) were being breastfed at 6 to 8 weeks. Breastfeeding rates vary across the Borough with less than 40% of babies being breastfed in some areas at 6 to 8 weeks.

We have estimated that of the 6000 births expected this year, 1000 babies will not be breastfed from birth and at least 1300 of them will not be breastfed at 6 to 8 weeks.

Breastfed babies have lower rates of: gastroenteritis, respiratory infections, allergies, ear infections and tooth decay. (139)

Being physically active and having a healthy diet are important from the earliest stages of life. (70)

The UK Chief Medical Officer recommends at least three hours of movement every day from birth to five years. (142)

Timely introduction to solid foods, a healthy family diet, along with physical activity are key to helping children maintain a healthy weight and healthy teeth. (143)(144)

Surveys of children’s weight and teeth at age five give us some idea about our success in helping Croydon children to be active and eat healthily.

Breastfeeding in Croydon

Examples of what we are doing in Croydon

• There are baby cafes with peer supporters and breastfeeding clinics in different localities in the Borough
• There is a peer support programme in Fieldway / New Addington where low breastfeeding rates were identified

Recommendations:

25. Reset targets for increasing breastfeeding rates at 6 to 8 weeks and 6 months across the Borough and within particular localities
26. Achieve level 3 of the UNICEF Baby Friendly award
27. Turn Croydon into a breastfeeding friendly Borough, so women feel comfortable breastfeeding when they are out and about (139)
What do we know about children’s teeth in Croydon?

Five year olds in Croydon have higher than the average levels of tooth decay. Over 28% of five year olds in 2016/2017 had experienced tooth decay. If this trend continues over 1700 of the 6000 babies born in Croydon this year will have tooth decay by the age of five which not only has an impact on them and their families, but puts them at increased risk of disease in their permanent adult teeth.

What do we know about the children’s weight in Croydon?

In 2017/2018 995 children (21.9%) in Croydon were overweight or obese in reception, which is similar to the London average. This is down from a peak of 1140 children (23.7%) in 2016/2017 which was the highest number since 2011/2012. Children from more deprived areas and from black ethnic groups have the highest levels of overweight or obesity.

If current trends continue 1300 of the 6000 babies born this year will be overweight or obese by the time they start school.

Child healthy weight, physical activity and diet

Examples of what we are doing in Croydon

- The early years providers (nurseries, childminders) are implementing a new programme to improve children’s health (Healthy Early Years London)
- There are healthy weight and food sessions for parents and young children at Children’s Centres
- Families, schools and early years providers are being encouraged to sign up to the Sugar Smart campaign

Recommendations

28. Review the Child Healthy Weight action plan in light of this report and amend to increase its focus on the first 1000 days
29. All families with young children, nurseries and other early years’ providers to be encouraged to become Sugar Smart and their pledges monitored. For example nurseries and early years providers to only be giving children in their care water and milk to drink by 2020
30. Increase the numbers of young children who go to the dentist
31. Increase the numbers of eligible families claiming their healthy start vouchers for fruit and vegetables and vitamins from pregnancy (uptake is currently 63%).
% measured children in Reception who were classified as overweight or obese 2014/15-2016/17
Adverse Childhood Experiences (ACEs) are a source of this chronic stress. ACEs include experiences such as abuse, domestic violence, neglect, homelessness, parental relationship breakdown, parental incarceration and substance misuse. ACEs are common, with about half of the population reporting that they had experienced at least one ACE between the ages of 0 to 18 years and 8% experiencing four or more ACEs. Many ACEs may be experienced in the first 1000 days of life.

Children who experience chronic stress from ACEs are more likely to develop antisocial and health harming habits and suffer from the earlier onset of chronic diseases as an adult. The more ACEs a child experiences the higher the risk of developing these health harming behaviours and suffering poor adult health.

ACEs affect children at all levels of income, however children growing up in poverty, are more likely to experience a greater number.

A UK study found that nearly 13% of children in the most deprived group experienced four or more ACEs compared to just over 4% in the least deprived group. Furthermore, as poverty itself increases stress it is likely to heighten the risk of ACEs.

A joint study with the WHO found that children who had experienced four or more ACEs compared with children who had experienced no ACES were:

- 30 times more likely to have attempted suicide
- 10 times more likely to have problem drug use
- 8 times more likely to have committed a crime
- 6 times more likely to have problem alcohol use
- 4 times more likely to have depression
- 4 times more likely to have been a teenage parent

Source: Felitti 1998. CDC, Image credit to Warren Larkin Associates Limited
People with four plus ACEs are more likely to have contact with health services than those with no ACEs. 152 153 For example, 64% of those in contact with substance misuse services had more than 4 ACEs

- 2.1 x more likely to have visited their GP in the last 12 months
- 2.2 x more likely to have visited A&E in the last 12 months
- 2.3 x more likely to have more than ten teeth removed

ACEs can also increase the risk to the child of asthma, gastrointestinal conditions and headaches; the higher number of ACEs a child has, the greater number of health problems. 132

It is incredibly important to emphasise that not everybody who experiences ACEs goes on to suffer from emotional and physical health problems.

ACEs and Resilience

DID YOU KNOW that one of the reasons ACEs are not detected early is that professionals and the public were not aware of the links between adverse experiences in early childhood and later problems? (155)

What do we know about ACES experienced in Croydon?

Using national survey data, we estimate that of the 6000 babies born each year almost 500 (8.4%) will have experienced four or more ACEs by the time they reach 18 years, placing them at very much higher risk of experiencing worse outcomes as an adult.

Children born into deprived communities are more likely to experience multiple ACEs. Of the estimated 1,200 babies in the least deprived group, approximately 50 will experience 4 or more ACEs, whereas three times that number, 150 of the 1,200 babies in the most deprived group will experience four or more ACEs. Using this same survey, we have estimated (below) the number of babies born in Croydon each year that will be affected by each type of ACE by the time they reach 18 years of age. Almost a quarter (1,422 babies) will experience two or more of them. (152)

National survey responses applied to the 6000 children born each year- in Croydon

<table>
<thead>
<tr>
<th>ACE Type</th>
<th>Percentage</th>
<th>Number</th>
</tr>
</thead>
<tbody>
<tr>
<td>Alcoholism</td>
<td>9%</td>
<td>540</td>
</tr>
<tr>
<td>Drug abuse</td>
<td>4%</td>
<td>240</td>
</tr>
<tr>
<td>Mental illness</td>
<td>12%</td>
<td>720</td>
</tr>
<tr>
<td>Incarceration</td>
<td>4%</td>
<td>240</td>
</tr>
<tr>
<td>Domestic violence</td>
<td>12%</td>
<td>720</td>
</tr>
<tr>
<td>Physical abuse</td>
<td>14.3%</td>
<td>858</td>
</tr>
<tr>
<td>Parental separation</td>
<td>22%</td>
<td>1320</td>
</tr>
</tbody>
</table>

The studies of ACEs have largely focused on how they have impacted on adult health and behaviour. I would, however, like to reflect briefly on how ACEs may already be affecting adolescents in Croydon.
What do we know about vulnerable adolescents in Croydon?

There are adolescents in Croydon whose risky and health harming behaviours may have their origins in the chronic stress caused by ACES in earlier childhood. Children excluded from school and those admitted to hospital for self-harm and alcohol are two possible examples.

We do not have a complete picture but we know that in Croydon there were: (PHE, 2018)

<table>
<thead>
<tr>
<th>Category</th>
<th>Number</th>
</tr>
</thead>
<tbody>
<tr>
<td>First time entrants to the youth justice system</td>
<td>223</td>
</tr>
<tr>
<td>Secondary school exclusions (2015/2016)</td>
<td>1452</td>
</tr>
<tr>
<td>Admissions for substance misuse among 15 to 24 year olds (2014/15–2016/2017)</td>
<td>91</td>
</tr>
<tr>
<td>Hospital admissions as a result of self-harm among 10 to 24 year olds (2016/2017)</td>
<td>166</td>
</tr>
<tr>
<td>Admissions for alcohol specific conditions for under 18s (2014/2015 to 2016/2017)</td>
<td>56</td>
</tr>
<tr>
<td>16 and 17 year olds not in education and training (2016)</td>
<td>970</td>
</tr>
</tbody>
</table>

We have a range of opportunities to identify and support children at higher risk of multiple ACES. To begin with, everyone working with children and their families’ needs to understand that ACES can have a profound impact on children and their life chances (155). Other key opportunities are reducing the underlying risk factors such as poverty, deprived neighbourhoods and poor housing and strengthening family relationships and community support so that where ACES do occur each child has the capacity to thrive despite circumstances.

Adverse childhood experiences

**Examples of what we are doing in Croydon**

- The council and its partners are focusing on prevention, engagement with residents and using intelligence to target evidence based and cost effective approaches.
- We are improving public realm through neighbourhood regeneration and increased use of parks and open spaces.

**Recommendations**

32. Working as a partnership, develop evidence based actions to champion the importance of ACES and the first 1000 days, and to identify and support children and families most vulnerable to ACES.

33. All (100%) of midwives and health visitors in Croydon to receive training around recognising and supporting families with risk of multiple Adverse Childhood Experiences by the end of 2019.

34. 1000 frontline staff in the council, NHS police and voluntary sector to have training around Adverse Childhood Experiences, their causes and impact in 2019.
I would like us all to ask ourselves: ‘Do I know what impacts on the health of children in their first 1000 days of life? And what can I, or my organisation, do to reduce inequalities?’

My three high level principles are:

**Know your role:** We all have a role to play in helping children thrive during the first 1000 days - however we need to understand what this role is and how best we can contribute through a whole systems approach.

**Health in all policies:** We all should shift the focus from managing ill health to creating the right conditions for good health through a health in all policies approach.

**Breaking the inequalities cycle:** Tackling the socio-economic determinants of health - (such as jobs, homes, social cohesion, education, income) is key in reducing the inequalities in early years that, in turn, become inequalities across the life course. We all have a role to play in breaking this cycle.

Throughout the report I have identified recommendations that will help us deliver these principles; some are specific and some more general that require further development and co-creation. (The full list is in appendix A) I recommend that the Health and Wellbeing take the responsibility for the oversight of these recommendations and the monitoring of their implementation and impact. My four key recommendations are:

1. Review, revise and join up the maternal mental health pathways from the community, and primary care, through midwifery and health visiting and other partners by 2019.

2. All (100%) of midwives and health visitors in Croydon to receive training around recognising and supporting families with risk of multiple Adverse Childhood Experiences by the end of 2019.

3. 1000 front line staff in the council, NHS, police and voluntary sector to have training around Adverse Childhood Experiences, their causes and impact, in 2019.

4. Develop and implement a plan of action for increasing the levels of awareness about pre pregnancy health and the importance of preparing for pregnancy by the end of 2019.

**EPILOGUE**

Writing this report has reminded me how early in life inequalities start, and that no single person or organisation can change this on their own. We have to work together to ensure that no child is left behind. My aim in this report was to share the evidence and highlight what we can do to give Croydon’s children the best possible chance.

I must stress again that the first 1000 days of a child’s life is inextricably linked with the lives and health of their parents and carers, neighbourhoods and communities. It is hugely important to reduce the impact that social and economic factors such as poor housing, low income and deprived neighbourhoods have on perpetuating inequalities.

What a child experiences in the first 2 years can be passed on to their own children which can trap some families and communities in a cycle of poorer outcomes. This is wrong.

Everything I have read has underlined the importance of prevention in breaking this cycle and has shown that there are many things we can do together to make a difference for our children. I know that Croydon is up for the challenge.

*“Childhood, after all, is the first precious coin that poverty steals from a child”* Anthony Horowitz

**VOICE OF CROYDON’S FUTURE:**

‘Women should breastfeed; Parents should make sure that they are in good health as well as their baby; They should keep in good shape and eat healthily; They should not neglect their child and make them feel loved and cared for’

**C, 13**
ACKNOWLEDGEMENTS

I would like to thank the project team (see below), in particular its leader and co-ordinator, Rachel Tilford and Damian Brewer for all their contributions to this report:

- Bernadette Alves
- Craig Ferguson
- Susan Mubiru
- Anna Ramsbottom
- Nicola Vousden

Many other people have contributed to this report along the way and I would just like to thank each and every one for their inputs and insight.

A very special thanks to Andy Martin, deputy manager of the council’s design team, for his patience and superb interpretation of my design ideas.

GIVE US YOUR FEEDBACK

Do let me know your comments on the report, either by emailing me at rachel.flowers@croydon.gov.uk

or by post to:

Croydon Council,
Public Health, Health, Wellbeing and Adults Department
2nd floor Zone E, Bernard Weatherill House
8 Mint Walk, Croydon, CR0 1EA
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APPENDIX A: THE RECOMMENDATIONS FROM DIRECTOR OF PUBLIC HEALTH REPORT 2018

Four key recommendations drawn from different chapters in the report

1. Review, revise and join up the maternal mental health pathways from the community, and primary care, through midwifery and health visiting and other partners by 2019.
2. All (100%) of midwives and health visitors in Croydon to receive training around recognising and supporting families with risk of multiple Adverse Childhood Experiences by the end of 2019.
3. 1000 front line staff in the council, NHS, police and voluntary sector to have training around Adverse Childhood Experiences, their causes and impact, in 2019.
4. Develop and Implement a plan of action for increasing the levels of awareness about pre pregnancy health and the importance of preparing for pregnancy by the end of 2019.

Knowledge about pre-pregnancy health and planning for pregnancy

6. All agencies to maximise their use of existing opportunities to raise awareness of the importance for both parents of planning for pregnancy and addressing health issues before becoming pregnant.
7. Use existing and new media to promote pre-pregnancy health messages, particularly about smoking and being overweight or obese for people living and working in Croydon.

Smoking and pregnancy

8. Develop a pathway for pregnant smokers and their partners into smoking cessation support that is opt out rather than opt in.
9. Identify the groups continuing to smoke through pregnancy and review the evidence base to identify the best approaches for helping them to stop smoking.
10. Develop a smoke free homes programme with social and private landlords.

Parental weight, diet and nutrition

11. Continue to provide senior strategic support to the partnership's Healthy Weight steering group, and ensure its work plan includes pre pregnancy health.
12. Ensure that all programmes that promote pre-pregnancy health (see previous recommendation box) include key messages around the importance of being a healthy weight and having a healthy diet before pregnancy.
13. Incorporate the recommendations of the London Mayor’s Food Strategy (due to be published in December 2018) into local plans.

Mental health in pregnancy and beyond

14. Review, revise and join up the maternal mental health pathways from the community, and primary care, through midwifery and health visiting and other partners by 2019.
15. Ensure all staff have the skills to identify parents and prospective parents with potential mental health concerns and are able support and signpost them appropriately.
16. Ensure that all programmes that promote pre-pregnancy health (see previous recommendation box) address mental health concerns before pregnancy.

Recommendations from individual sections of the report

The setting for the first 1000 days

1. Ensure training raises awareness among staff of: the importance of the first 1000 days and pre pregnancy health; the impact of wider determinants such as poverty and how they can make a difference in their role for children and their families.
2. Use population and community level intelligence at borough and locality level to target resources and services to those Young parents.
3. Provide senior strategic support from across the partnership to the borough's teenage pregnancy action plan and ensure that its work is widely understood and linked to other strategies and programmes.
4. Increase awareness among young people of all sexes of the importance of being healthy before pregnancy and planning pregnancies through implementation of the teenage pregnancy action plan and maximising the opportunities created by the statutory changes both in SRE (sex and relationship) education and in PSHE (personal, social, health and economic) education.
5. Ensure the findings of Croydon’s Vulnerable Adolescent Mental Health deep dive are acted upon to identify when, where and how to provide support to children and teenagers.

Knowledge about pre-pregnancy health and planning for pregnancy

6. All agencies to maximise their use of existing opportunities to raise awareness of the importance for both parents of planning for pregnancy and addressing health issues before becoming pregnant.
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Mental health in pregnancy and beyond

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15. Ensure all staff have the skills to identify parents and prospective parents with potential mental health concerns and are able support and signpost them appropriately.
16. Ensure that all programmes that promote pre-pregnancy health (see previous recommendation box) address mental health concerns before pregnancy.
Relationships, social support and excess stress during pregnancy
17. Review the effectiveness of the current arrangements for identifying women who need more social support and make recommendations to address any system wide gaps that are identified.
18. All (100%) of midwives and health visitors in Croydon to receive training around recognising and supporting families with risk of multiple Adverse Childhood Experiences by the end of 2019.
19. 1000 frontline staff in the council, NHS police and voluntary sector to have training around Adverse Childhood Experiences, their causes and impact in 2019

Positive environments, child development and stress in infancy
20. Ensure maximum delivery of the health visiting development checks, from the antenatal visit to the 2 year check
21. Ensure all parents who may need additional support know what options are on offer and where to access them.
22. All practitioners working with children and families understand what toxic stress is, its sources and what impact it may have

Immunisation rates in Croydon
23. All GP practices to reach 95% of MMR immunisations
24. Implement comprehensive vaccination for vulnerable groups

Breastfeeding in Croydon
25. Reset targets for increasing breastfeeding rates at 6 to 8 weeks and 6 months across the Borough and within particular localities
26. Achieve level 3 of the UNICEF Baby Friendly award
27. Turn Croydon into a breastfeeding friendly Borough, so women feel at ease to breastfeed when they are out and about (PHE, 2016)

Child healthy weight
28. Review the Child Healthy Weight action plan in light of this report and amend to increase its focus on the first 1000 days.
29. All families with young children, nurseries and other early years' providers to be encouraged to become Sugar Smart and their pledges monitored. For example nurseries and early years providers to only be giving children in their care water and milk to drink by 2020
30. Increase the numbers of young children who go to the dentist
31. Increase the numbers of eligible families claiming their healthy start vouchers for fruit and vegetables and vitamins from pregnancy (uptake is currently 63%).

Adverse childhood experiences in Croydon
32. Working as a partnership, develop evidence based actions to champion the importance of ACEs and the first 1000 days, and to identify and support children and families most vulnerable to ACEs
33. All (100%) of midwives and health visitors in Croydon to receive training around recognising and supporting families with risk of multiple Adverse Childhood Experiences by the end of 2019.
34. 1000 frontline staff in the council, NHS police and voluntary sector to have training around Adverse Childhood Experiences, their causes and impact in 2019
WE ARE CROYDON

EARLY EXPERIENCES LAST A LIFE TIME
The first 1000 days from conception to the age of 2

DIRECTOR OF PUBLIC HEALTH
ANNUAL REPORT 2018
Purpose of the paper

To report on the Trust’s quality and 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:

- A review of community service redesign across the four Boroughs, linked to agreed ICare design principles and emerging Alliance and Partnership agreements is underway. This work will also support preparation for the upcoming CQC inspection of Community Services;

- The Trust continues to meet it regulatory target for IAPT, Dementia and Early Intervention in Psychosis;

- Work continues to reduce CAMHS waiting lists linked to increasing investment into service to deliver capacity aligned local borough demand;

- The commissioning and contracting round for 2019/20 is progressing positively with CCGs and the SEL STP with a coordinated approach across all commissioners and securing the agreement to transfer both commissioning budgets and functions;

- The Trust is delivering a continued reduction in prone restraint being used in Lambeth, an improvement in response and investigation timeframes with both complaints and serious incidents. Since July the QuESTTT tool scoring has also resulted in an increase in action plans being received and monitored in the monthly Quality governance compliance meetings. Due to the Trust’s focus on restraint, we expect reporting to increase and become more accurate and therefore expect the number of total reported incidents to increase before reducing again;

- Delivery of the Trust ‘Our Improvement Plan’ continues at pace across the Boroughs with delivery now shifting from the input of actions that have been delivered to monitoring the measurement strategy that will enable the Trust to track the outcome / improvement impact of actions delivered. Performance metrics are now included within the report in Section 3; and

- Daily meetings have been set up to review flow plan implementation and drive down private sector overspill.
**Risks / issues for escalation**

BAF Risk 1 - Workforce

BAF Risk 2 – operational delivery structure.

BAF Risk 3 – Informatics

BAF Risk 5 - Partnership working with service users.

BAF Risk 7 - Quality & statutory compliance.

BAF Risk 8 - Finance - contracts.

BAF Risk 9 – Estates

BAF Risk 11 - QI delivery.

BAF Risk 12 Finance – cost management

BAF Risk 13 – Mandatory training

BAF Risk 14 – Patient flow
PERFORMANCE AND QUALITY REPORT

1. Quality Indicators Compliance
2. NHS Improvement Indicators and Trust Data Strategy
3. Operational Performance and Activity
4. Updates from Our Improvement Plan Meetings and Performance and Quality Meetings

5.1 Mandatory Training Compliance

5.1.1 Trust-wide actions to improve compliance
5.1.2 Actions in relation to specific subjects

6. Commissioning and Contracting

7. Emergency Preparedness Resilience and Response Assurance (EPRR)

8. Conclusion
1. Quality Indicators Compliance

This section outlines the compliance and performance against current quality and safety indicators. To note is the continued reduction in prone restraint being used in Lambeth (fig 11), the improvement in response and investigation timeframes with both complaints and serious incidents.

1.1 Patient Safety Quality Indicators

Incidents

The Trust continues to monitor the number of incidents reported and the time taken to approve incidents. The number of incidents is reported by week. The overall trend has been to higher reporting rates overall, the continued move to SPC charts will demonstrate this more clearly.

The graph below outlines national benchmarking data from the quarterly CQC insight reports on the number of patient safety incidents reported. As with the last quarter (Nov 2018) the data outlined in Fig. 2 below, ‘S’ stands for ‘about the same’ as other trusts. This figure indicates an improvement on the previous year when the trust was rated in the lowest 25% of reporters.
Fig. 2. Comparative reporting rate for incidents in mental health trusts. Source: CQC Insight for NHS Trusts and Community Interest (January 2019)

14,700 incidents reported on Datix:

<table>
<thead>
<tr>
<th>Incidents By Severity</th>
<th>01/01/18-31/01/19</th>
<th>Jan-19</th>
</tr>
</thead>
<tbody>
<tr>
<td>A - Death</td>
<td>635</td>
<td>59</td>
</tr>
<tr>
<td>B - Severe</td>
<td>157</td>
<td>15</td>
</tr>
<tr>
<td>C - Moderate</td>
<td>5151</td>
<td>599</td>
</tr>
<tr>
<td>D - Low</td>
<td>5735</td>
<td>422</td>
</tr>
<tr>
<td>E - No Adverse Outcome</td>
<td>3022</td>
<td>212</td>
</tr>
<tr>
<td>Total</td>
<td>14700</td>
<td>1307</td>
</tr>
</tbody>
</table>

Fig 3: Total incidents by severity, Source; Datix

The top 5 reported categories were:

<table>
<thead>
<tr>
<th>Top 5 Reported Categories</th>
<th>Jan-19</th>
</tr>
</thead>
<tbody>
<tr>
<td>Assault By PATIENT (Including Alleged)</td>
<td>247</td>
</tr>
<tr>
<td>Challenging Behaviour</td>
<td>187</td>
</tr>
<tr>
<td>Actual Self-harm</td>
<td>111</td>
</tr>
<tr>
<td>Administration Or Medication On Clinical Units (Ward/HTT)</td>
<td>79</td>
</tr>
<tr>
<td>Abscond - Sectioned Patient</td>
<td>57</td>
</tr>
<tr>
<td>Total</td>
<td>681</td>
</tr>
</tbody>
</table>

Fig 4: Total incidents by top 5 categories Source; Datix

Fig 5: Total reported ‘Death’ incidents, Source; Datix
Deaths

<table>
<thead>
<tr>
<th>Cause Of Death</th>
<th>Jan-19</th>
</tr>
</thead>
<tbody>
<tr>
<td>Probable Suicide</td>
<td>6</td>
</tr>
<tr>
<td>Natural Causes</td>
<td>27</td>
</tr>
<tr>
<td>Cause Of Death Unknown At Time Of Reporting</td>
<td>24</td>
</tr>
<tr>
<td>Homicide (Murder) BY Patient</td>
<td>1</td>
</tr>
<tr>
<td>Death Due To Accidental Overdose</td>
<td>1</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>59</strong></td>
</tr>
</tbody>
</table>

Fig 6: Total reported ‘Death’ incidents by category (Jan 2019), Source; Datix

**Preventing Future Death Reports**

The Trust received 1 Preventing Future Death (PFD) report in Q3 following an inquest in Q2 where a narrative outcome was given. The response to the PFD report has been sent to the Coroner. There are currently no outstanding PFD reports.

Themes and subsequent actions have resulted:

1. Trust has enhanced process for monitoring compliance with and quality of care plans and risk assessments - Oversight at performance and Quality meetings.
2. Revised Sec 17 leave Policy (2018)
3. On Ward, review of care planning and new risk information within the team through the introduction of a daily Consultant led review.
4. Improved Out of Hours medical Cover.
5. New Borough management Structures.

**Central Alerting System (CAS) Alerts**

The Trust received 8 safety alerts in January 2019 from the Central Alerting System (CAS). Of note is a NHSI Estates and Facilities Alert relating to portable fans in health and social care facilities: risk of cross infection (EFA/2019/001). This has been discussed at the H&S Committee and a working group led by the Assistant Director of Infection Control is currently reviewing the risk and developing an action plan for SlaM.

<table>
<thead>
<tr>
<th>Type of Alert</th>
<th>Acknowledged</th>
<th>Action Completed</th>
<th>Action Not Required</th>
<th>Action Underway</th>
<th>Response Not Required</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Chief Medical Officer (CMO) Messaging</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>DHSC Supply Disruption Alert</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Medicines and Healthcare products Regulatory Agency (MHRA) Dear Doctor Letter</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>MHRA Drug Alerts</td>
<td>2</td>
<td>0</td>
<td>2</td>
<td>0</td>
<td>2</td>
<td>2</td>
</tr>
<tr>
<td>MHRA Medical Device Alerts</td>
<td>5</td>
<td>0</td>
<td>4</td>
<td>1</td>
<td>0</td>
<td>5</td>
</tr>
<tr>
<td>NHS Improvement</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>NHS Improvement Estates and Facilities</td>
<td>1</td>
<td>0</td>
<td>0</td>
<td>1</td>
<td>0</td>
<td>1</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>8</strong></td>
<td><strong>0</strong></td>
<td><strong>6</strong></td>
<td><strong>2</strong></td>
<td><strong>2</strong></td>
<td><strong>8</strong></td>
</tr>
</tbody>
</table>

Fig 7: CAS Alerts received, Q2. Source; Patient Safety team
Violence and Aggression

Quality priority: Reducing violence by 50% over 3 years

The number of reported incidents of violence and aggression appears to be on an increasing trajectory. With a focus on restrictive practice and violence reduction it is expected that the quality of the data will improve and thus is likely to increase before reducing again. Another factor likely contributing to this increase is the addition of the CAMHS PICU in April 2018. The data will be looked at closely at the end of April 2019 reporting period and consideration given to resetting the mean.

Use of restraint

Quality priority: Reduction in restraint by 50% in over 3 years
Fig 9: Total Reported incidents of Restraint, Apr 2017 – Jan 2019. Source: Datix

Fig 10: Total duration of restraint (minutes), Source: Datix

Duration of restraints is examined in the weekly Senior Leadership Safety Huddles. Specifically, there is a focus on prone restraints in excess of 3 minutes and restraints in any position last for 10 minutes of more. Prone restraints of 3 minutes or more appear to be reducing. The data is being plotted onto an SPC chart to consider carefully if the duration of restraint over time is changing.

Quality Priority

Quality priority: Reduce use of prone restraint to zero within 3 years

Fig 11: Total reported incidents of prone restraint, Source: Datix
Due to the Trust’s focus on restraint, we expect reporting to increase and become more accurate and therefore expect the number of total reported incidents to increase before reducing again. At present, the graphs above do not show any indicators of change Trust wide, there have been local areas of change, for example, Fig. 12 shows continued local area of change for the number of prone restraints in Lambeth. In the acute care pathway when viewed together there has been a sustained reduction in the use of prone of the last 8 months. This is with the exception of two wards in the Southwark Directorate, a PICU and the Place of Safety. The local directorate and lead nurse for restrictive practice are working with the teams to better understand what is driving the use of prone restraint and what support they need.

Of note in Fig. 12 there are two outliers at the end of 2018 into early 2019 that do not follow the general trends seen elsewhere. These are the Southwark and CAMHS Directorates. With regard to the former, this spike during November, December and January is accounted for by two services; the Female PICU and the Place of Safety. As noted above targeted work is under way with these teams. The CAMHS directorate increase is driven by the CAMHS PICU who as a new service experienced an incredibly challenging period where seclusion use was frequently required. A significant proportion of these prone restraints are accounted for the use of the position to safely exit seclusion. With the Promoting Safe and Therapeutic Services Training team we are in the process of ordering some additional equipment, initially for areas with seclusion rooms, which will negate the need for the use of prone in this setting.

**Quality Priority: Reduce the use of rapid tranquilisation by 25% over the next 3 years**

The main focus with the work around Rapid Tranquillisation has been to ensure that where it is being used in the Trust it is done so safely and with appropriate physical health monitoring. This has had two impacts that are not apparent from Fig. 14. Firstly, there are some indications that Lewisham Directorate may be seeing a downward shift in the rates of rapid tranquillisation usage including a two week period in the male PICU where no Rapid Tranquillisations has been used at all.
The reviewed seclusion policy was ratified and published at the end of December 2018. There is an associated multidisciplinary QI project focused on the implementation of this policy and in particular the reduction of seclusion (incidents and duration). There is a question about a possible increase in seclusion related to a possible decrease in rapid tranquilisation, we are looking at this data closely and over time to establish if there is a correlation or not.

An update to ePJS was also implemented in line with the new policy and providing automated alerts when seclusion is used. It is envisaged this will facilitate improved oversight and the contribution of senior leadership in addressing what is one of the Trusts most significant restrictive practices.
1.2 Patient Safety Quality 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. Fig. 17 indicates the average time for investigations is reducing. A total of 19 have been reported to STEIS since January 2019.

Safeguarding Concerns

Fig 18: Number of Safeguarding Adults ConcernsFig 19: Number of safeguarding Children Source; Datix Concerns, Source; Datix
1.3 Patient Experience

Complaints

In January, the primary subject of 37% of formal complaints related to care and treatment ($n=15$) and 27% related to attitude and behaviour. A further 10% related to discharge and 7% communication.
Quality Alerts

Quality Alerts are a process to review and respond to concerns raised mainly by GPs (but also other health organisations or partners such as the police or third sector agencies) on behalf of their patients or clients. Urgent concerns about patient care are excluded from this process. A total of seven Quality Alerts were received in January; four were raised by GPs and three by another NHS trust. The primary subjects were communication (2), discharge (2) and other (3).
PEDIC/Friends and Family Test (FFT)

**Quality Priority**

**Quality Priority** – Increase to 90% the number of patients who would recommend the service to friends or family if they needed similar care or treatment

In January 2018, the FFT response rate for the trust was 84%, which has been maintained or surpassed since September 2018.

![Fig. 25: PEDIC Scores (positive)](image)

![Fig. 26: Family and Friends (FFT) scores (positive)](image)

**Risk Assessment and Care Plans**

**Quality Priority**

**Quality Priority** – Increase the number of care plans devised collaboratively with service users over the next three years

![Fig. 27: Trust quality audit scores (inpatient and community risk assessment and care plans)](image)
The Nursing executive are currently reviewing all the SNAP audit tools to ensure standardisation in both use and scope.

**Identification of carers, friends and family**

**Quality Priority**

**Quality Priority – Increase the number of identified carers, friends and family for a person in receipt of care**

Current trust performance of 50.5% is a slight increase from the previous month of 50.3%. This includes the following roles recorded and counted under the field ‘Role’ on ePJS: Carer; Family member; Children’s guardian; Nearest relative; Next of kin; Friend; Resident; Non-resident parent. It also includes anything that is written under the field ‘Relationship’.

<table>
<thead>
<tr>
<th>Directorate</th>
<th>Patients</th>
<th>% Supported</th>
</tr>
</thead>
<tbody>
<tr>
<td>Addictions</td>
<td>2,412</td>
<td>64.0%</td>
</tr>
<tr>
<td>BDP</td>
<td>7,199</td>
<td>23.7%</td>
</tr>
<tr>
<td>CAMHS</td>
<td>7,293</td>
<td>63.6%</td>
</tr>
<tr>
<td>Croydon</td>
<td>2,931</td>
<td>60.9%</td>
</tr>
<tr>
<td>Lambeth</td>
<td>2,448</td>
<td>62.6%</td>
</tr>
<tr>
<td>Lewisham</td>
<td>2,900</td>
<td>64.1%</td>
</tr>
<tr>
<td>PMIC</td>
<td>3,425</td>
<td>31.2%</td>
</tr>
<tr>
<td>Southwark</td>
<td>3,138</td>
<td>52.6%</td>
</tr>
<tr>
<td><strong>Trustwide Total</strong></td>
<td><strong>33,027</strong></td>
<td><strong>50.5%</strong></td>
</tr>
</tbody>
</table>

Fig 29: % Patients Supported by Directorate, Source; Trust Dashboard
1.4 Compliance Indicators

Compliance Indicators – Ligatures

Ligature audits for 62 sites have been completed and are in date for 2018/19.

<table>
<thead>
<tr>
<th>Operation Directorate</th>
<th>Audits 2017/18</th>
<th>Audits 2018/19</th>
</tr>
</thead>
<tbody>
<tr>
<td>CAMHS</td>
<td>All audits completed. 1 ward closed all year.</td>
<td>All audits completed.</td>
</tr>
<tr>
<td>Croydon &amp; Forensics</td>
<td>All audits completed.</td>
<td>All audits completed.</td>
</tr>
<tr>
<td>Lambeth</td>
<td>All audits completed.</td>
<td>All audits completed.</td>
</tr>
<tr>
<td>Lewisham</td>
<td>All audits completed.</td>
<td>All audits completed.</td>
</tr>
<tr>
<td>PMOA</td>
<td>All audits completed.</td>
<td>All audits completed.</td>
</tr>
<tr>
<td>Southwark &amp; Addictions</td>
<td>All audits completed.</td>
<td>All audits completed.</td>
</tr>
</tbody>
</table>

Fig. 30: Ligature Audits 2018/19

Compliance Indicators - Infection Control

<table>
<thead>
<tr>
<th>Conditions</th>
<th>Status</th>
</tr>
</thead>
<tbody>
<tr>
<td>MRSA, CMRSA, PVL* etc.</td>
<td>There have been no cases.</td>
</tr>
<tr>
<td>C. difficile</td>
<td>There have been no cases.</td>
</tr>
<tr>
<td>Antibiotic resistant infections, e.g. ESBL**</td>
<td>There have been no cases.</td>
</tr>
<tr>
<td>Diarrhoea &amp; Vomiting outbreaks</td>
<td>** Tyson West 1, Bethlem Royal Hospital – Commenced 18th January 2019. 2 patients were affected. Ward closed until 21st January. * Panton Valentine Leucocidin ** Extended spectrum beta-lactamases</td>
</tr>
</tbody>
</table>

Compliance Indicators - NICE guidance and Quality Standards

The two tables below Fig 32 and Fig 33 provides details on the annual clinical guidance & quality standard figures. The table details where gap analysis has been received, is still outstanding, in progress, was deemed N/A, or where a decision is still awaited on whether the guidance is relevant to the Trust (pending). These are being monitored via the performance and quality meetings. The older outstanding guidelines are where there has been partial review but remaining further input for sign off.

<table>
<thead>
<tr>
<th>Year</th>
<th>Received</th>
<th>Outstanding</th>
<th>In Progress</th>
<th>N/A</th>
<th>Pending</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>2015/2016</td>
<td>16</td>
<td>0</td>
<td>0</td>
<td>3</td>
<td>0</td>
<td>19</td>
</tr>
<tr>
<td>2016/2017</td>
<td>12</td>
<td>2</td>
<td>0</td>
<td>3</td>
<td>0</td>
<td>17</td>
</tr>
<tr>
<td>2017/2018</td>
<td>15</td>
<td>2</td>
<td>0</td>
<td>10</td>
<td>0</td>
<td>27</td>
</tr>
<tr>
<td>2018/2019*</td>
<td>1</td>
<td>2</td>
<td>8</td>
<td>2</td>
<td>0</td>
<td>13</td>
</tr>
</tbody>
</table>

Fig. 32: NICE Guidelines – Outstanding Gap Analysis, Source; Quality team
<table>
<thead>
<tr>
<th>Year</th>
<th>Received</th>
<th>Outstanding</th>
<th>In Progress</th>
<th>N/A</th>
<th>Pending</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>2015/2016</td>
<td>14</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>14</td>
</tr>
<tr>
<td>2016/2017</td>
<td>8</td>
<td>0</td>
<td>0</td>
<td>2</td>
<td>0</td>
<td>10</td>
</tr>
<tr>
<td>2017/2018</td>
<td>4</td>
<td>3</td>
<td>0</td>
<td>4</td>
<td>0</td>
<td>11</td>
</tr>
<tr>
<td>2018/2019</td>
<td>1</td>
<td>0</td>
<td>0</td>
<td>3</td>
<td>0</td>
<td>4</td>
</tr>
</tbody>
</table>

Fig. 33: NICE Quality Standards – Outstanding Gap Analysis, Source; Quality team

1.5 QUESTT

In December 2018 as with November 2018, two wards scored red, the Health-Based Place of Safety (HBPoS) and Eileen Skellern 1 (PICU) (ES1). The areas which related to the Red score were staffing, supervision and unusual demand and high acuity. The action plans for both Red and Amber are being monitored via the Operations Directorate monthly Performance and Quality meetings. There will be a fuller report to the Quality Committee outlining these actions in full.
## 2. NHS Improvement Indicators and Trust Data Strategy

A summary of performance against key indicators for Dementia, IAPT and Early Intervention in each of the 4 Boroughs is set out below:

### Croydon IAPT

<table>
<thead>
<tr>
<th>Month</th>
<th>Dec</th>
<th>Jan</th>
<th>Feb</th>
<th>Mar</th>
<th>Apr</th>
<th>May</th>
<th>Jun</th>
<th>Jul</th>
<th>Aug</th>
<th>Sep</th>
<th>Oct</th>
<th>Nov</th>
<th>Dec</th>
</tr>
</thead>
<tbody>
<tr>
<td>Recovery rate target (50%)</td>
<td>11.7%</td>
<td>47.3%</td>
<td>38.2%</td>
<td>16.4%</td>
<td>47.1%</td>
<td>22.8%</td>
<td>59.3%</td>
<td>55.0%</td>
<td>66.7%</td>
<td>71.8%</td>
<td>72.0%</td>
<td>46.4%</td>
<td></td>
</tr>
<tr>
<td>Waiting time 3 weeks (Target: 75%)</td>
<td>90.0%</td>
<td>95.0%</td>
<td>94.0%</td>
<td>96.0%</td>
<td>98.0%</td>
<td>99.0%</td>
<td>98.0%</td>
<td>97.0%</td>
<td>97.0%</td>
<td>97.0%</td>
<td>97.0%</td>
<td>99.2%</td>
<td>99.4%</td>
</tr>
<tr>
<td>Waiting Time 6 weeks (Target: 85%)</td>
<td>90.0%</td>
<td>90.0%</td>
<td>90.0%</td>
<td>90.0%</td>
<td>90.0%</td>
<td>90.0%</td>
<td>90.0%</td>
<td>90.0%</td>
<td>90.0%</td>
<td>90.0%</td>
<td>90.0%</td>
<td>90.0%</td>
<td>90.0%</td>
</tr>
</tbody>
</table>

### Croydon Dementia Diagnosis

<table>
<thead>
<tr>
<th>Month</th>
<th>Dec</th>
<th>Jan</th>
<th>Feb</th>
<th>Mar</th>
<th>Apr</th>
<th>May</th>
<th>Jun</th>
<th>Jul</th>
<th>Aug</th>
<th>Sep</th>
<th>Oct</th>
<th>Nov</th>
<th>Dec</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total diagnosis referrals</td>
<td>1308</td>
<td>1386</td>
<td>1375</td>
<td>1375</td>
<td>1304</td>
<td>1398</td>
<td>1353</td>
<td>1342</td>
<td>1342</td>
<td>1343</td>
<td>1342</td>
<td>1339</td>
<td>1347</td>
</tr>
<tr>
<td>Active number of referrals</td>
<td>1264</td>
<td>1319</td>
<td>1319</td>
<td>1291</td>
<td>1286</td>
<td>1286</td>
<td>1286</td>
<td>1284</td>
<td>1284</td>
<td>1284</td>
<td>1284</td>
<td>1284</td>
<td>1284</td>
</tr>
</tbody>
</table>

### Croydon Early Intervention in Psychosis

<table>
<thead>
<tr>
<th>Quart</th>
<th>Q1 (17/18)</th>
<th>Q2 (17/18)</th>
<th>Q3 (17/18)</th>
<th>Q4 (17/18)</th>
<th>Q1 (18/19)</th>
<th>Q2 (18/19)</th>
<th>Q3 (18/19)</th>
<th>Q4 (18/19)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Number of referrals to and within the Trust with suspect first episode psychosis or at risk mental state that start a NICE-recommended care package in the reporting period within 2 weeks of referral</td>
<td>9</td>
<td>17</td>
<td>17</td>
<td>8</td>
<td>12</td>
<td>22</td>
<td>28</td>
<td>n/a</td>
</tr>
<tr>
<td>Number of referrals to and within the Trust with suspect first episode psychosis or at risk mental state that start a NICE-recommended care package in the reporting period within 6 weeks of referral</td>
<td>13</td>
<td>20</td>
<td>21</td>
<td>18</td>
<td>17</td>
<td>26</td>
<td>31</td>
<td>n/a</td>
</tr>
<tr>
<td>Actual %</td>
<td>80%</td>
<td>60%</td>
<td>81%</td>
<td>44%</td>
<td>71%</td>
<td>88%</td>
<td>90%</td>
<td>n/a</td>
</tr>
<tr>
<td>Target %</td>
<td>50%</td>
<td>60%</td>
<td>50%</td>
<td>50%</td>
<td>50%</td>
<td>50%</td>
<td>50%</td>
<td>n/a</td>
</tr>
</tbody>
</table>

### Lambeth IAPT

<table>
<thead>
<tr>
<th>Month</th>
<th>Dec</th>
<th>Jan</th>
<th>Feb</th>
<th>Mar</th>
<th>Apr</th>
<th>May</th>
<th>Jun</th>
<th>Jul</th>
<th>Aug</th>
<th>Sep</th>
<th>Oct</th>
<th>Nov</th>
<th>Dec</th>
</tr>
</thead>
<tbody>
<tr>
<td>Monthly 1st treatments</td>
<td>485</td>
<td>485</td>
<td>485</td>
<td>485</td>
<td>485</td>
<td>485</td>
<td>485</td>
<td>485</td>
<td>485</td>
<td>485</td>
<td>485</td>
<td>485</td>
<td>485</td>
</tr>
<tr>
<td>Number of first treatments</td>
<td>485</td>
<td>485</td>
<td>485</td>
<td>485</td>
<td>485</td>
<td>485</td>
<td>485</td>
<td>485</td>
<td>485</td>
<td>485</td>
<td>485</td>
<td>485</td>
<td>485</td>
</tr>
<tr>
<td>Recovery rate target (50%)</td>
<td>11.7%</td>
<td>47.3%</td>
<td>38.2%</td>
<td>16.4%</td>
<td>47.1%</td>
<td>22.8%</td>
<td>59.3%</td>
<td>55.0%</td>
<td>66.7%</td>
<td>71.8%</td>
<td>72.0%</td>
<td>46.4%</td>
<td></td>
</tr>
<tr>
<td>Waiting time 3 weeks (Target: 75%)</td>
<td>90.0%</td>
<td>95.0%</td>
<td>94.0%</td>
<td>96.0%</td>
<td>98.0%</td>
<td>99.0%</td>
<td>98.0%</td>
<td>97.0%</td>
<td>97.0%</td>
<td>97.0%</td>
<td>97.0%</td>
<td>97.0%</td>
<td>99.2%</td>
</tr>
<tr>
<td>Waiting Time 6 weeks (Target: 85%)</td>
<td>90.0%</td>
<td>90.0%</td>
<td>90.0%</td>
<td>90.0%</td>
<td>90.0%</td>
<td>90.0%</td>
<td>90.0%</td>
<td>90.0%</td>
<td>90.0%</td>
<td>90.0%</td>
<td>90.0%</td>
<td>90.0%</td>
<td>90.0%</td>
</tr>
</tbody>
</table>

### Lambeth Dementia Diagnosis

<table>
<thead>
<tr>
<th>Month</th>
<th>Dec</th>
<th>Jan</th>
<th>Feb</th>
<th>Mar</th>
<th>Apr</th>
<th>May</th>
<th>Jun</th>
<th>Jul</th>
<th>Aug</th>
<th>Sep</th>
<th>Oct</th>
<th>Nov</th>
<th>Dec</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total diagnosis referrals</td>
<td>128</td>
<td>126</td>
<td>126</td>
<td>126</td>
<td>126</td>
<td>126</td>
<td>126</td>
<td>126</td>
<td>126</td>
<td>126</td>
<td>126</td>
<td>126</td>
<td>126</td>
</tr>
<tr>
<td>Active number of referrals</td>
<td>128</td>
<td>126</td>
<td>126</td>
<td>126</td>
<td>126</td>
<td>126</td>
<td>126</td>
<td>126</td>
<td>126</td>
<td>126</td>
<td>126</td>
<td>126</td>
<td>126</td>
</tr>
</tbody>
</table>

### Lambeth Early Intervention in Psychosis

<table>
<thead>
<tr>
<th>Quart</th>
<th>Q1 (17/18)</th>
<th>Q2 (17/18)</th>
<th>Q3 (17/18)</th>
<th>Q4 (17/18)</th>
<th>Q1 (18/19)</th>
<th>Q2 (18/19)</th>
<th>Q3 (18/19)</th>
<th>Q4 (18/19)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Number of referrals to and within the Trust with suspect first episode psychosis or at risk mental state that start a NICE-recommended care package in the reporting period within 2 weeks of referral</td>
<td>9</td>
<td>17</td>
<td>17</td>
<td>8</td>
<td>12</td>
<td>22</td>
<td>28</td>
<td>n/a</td>
</tr>
<tr>
<td>Number of referrals to and within the Trust with suspect first episode psychosis or at risk mental state that start a NICE-recommended care package in the reporting period within 6 weeks of referral</td>
<td>13</td>
<td>20</td>
<td>21</td>
<td>18</td>
<td>17</td>
<td>26</td>
<td>31</td>
<td>n/a</td>
</tr>
<tr>
<td>Actual %</td>
<td>80%</td>
<td>60%</td>
<td>81%</td>
<td>44%</td>
<td>71%</td>
<td>88%</td>
<td>90%</td>
<td>n/a</td>
</tr>
<tr>
<td>Target %</td>
<td>50%</td>
<td>60%</td>
<td>50%</td>
<td>50%</td>
<td>50%</td>
<td>50%</td>
<td>50%</td>
<td>n/a</td>
</tr>
</tbody>
</table>

---

Page 114 of 271
### Lambeth Early Intervention in Psychosis

<table>
<thead>
<tr>
<th>Month</th>
<th>Q1 17/18</th>
<th>Q2 17/18</th>
<th>Q3 17/18</th>
<th>Q4 17/18</th>
<th>Q1 18/19</th>
<th>Q2 18/19</th>
<th>Q3 18/19</th>
<th>Q4 18/19</th>
</tr>
</thead>
<tbody>
<tr>
<td>Number of referrals to and within the Trust with suspected first episode psychosis or at ‘high mental state’ that start a NICE-recommended package care package in the reporting period within 2 weeks of referral:</td>
<td>9</td>
<td>12</td>
<td>17</td>
<td>10</td>
<td>28</td>
<td>20</td>
<td>12</td>
<td>n/a</td>
</tr>
<tr>
<td>Number of referrals to and within the Trust with suspected first episode psychosis or at ‘high mental state’ that start a NICE-recommended package care package</td>
<td>13</td>
<td>20</td>
<td>21</td>
<td>16</td>
<td>30</td>
<td>28</td>
<td>26</td>
<td>n/a</td>
</tr>
<tr>
<td>Actual %</td>
<td>97%</td>
<td>56%</td>
<td>61%</td>
<td>62%</td>
<td>67%</td>
<td>79%</td>
<td>60%</td>
<td>n/a</td>
</tr>
<tr>
<td>Target %</td>
<td>55%</td>
<td>56%</td>
<td>52%</td>
<td>56%</td>
<td>55%</td>
<td>58%</td>
<td>55%</td>
<td>n/a</td>
</tr>
</tbody>
</table>

### Lewisham IAPT

<table>
<thead>
<tr>
<th>Month</th>
<th>Dec</th>
<th>Jan</th>
<th>Feb</th>
<th>Mar</th>
<th>Apr</th>
<th>May</th>
<th>Jun</th>
<th>Jul</th>
<th>Aug</th>
<th>Sep</th>
<th>Oct</th>
<th>Nov</th>
<th>Dec</th>
</tr>
</thead>
<tbody>
<tr>
<td>Monthly 1st treatments required to achieve access target by Q4</td>
<td>472</td>
<td>529</td>
<td>529</td>
<td>529</td>
<td>529</td>
<td>529</td>
<td>529</td>
<td>529</td>
<td>529</td>
<td>529</td>
<td>529</td>
<td>529</td>
<td>529</td>
</tr>
<tr>
<td>Number of first treatments</td>
<td>360</td>
<td>408</td>
<td>548</td>
<td>409</td>
<td>465</td>
<td>870</td>
<td>515</td>
<td>505</td>
<td>608</td>
<td>573</td>
<td>661</td>
<td>637</td>
<td>411</td>
</tr>
<tr>
<td>Recovery rate (target: 50%) - Local data</td>
<td>51.8%</td>
<td>53.5%</td>
<td>53.2%</td>
<td>54.7%</td>
<td>52.0%</td>
<td>51.0%</td>
<td>53.0%</td>
<td>52.0%</td>
<td>50.0%</td>
<td>50.0%</td>
<td>51.5%</td>
<td>48.7%</td>
<td>50.7%</td>
</tr>
<tr>
<td>Published Recovery Rate</td>
<td>56.0%</td>
<td>56.0%</td>
<td>55.9%</td>
<td>54.0%</td>
<td>50.9%</td>
<td>52.9%</td>
<td>54.0%</td>
<td>51.9%</td>
<td>49.0%</td>
<td>56.0%</td>
<td>49.1%</td>
<td>tbc</td>
<td>tbc</td>
</tr>
<tr>
<td>Waiting Time: 6 weeks (Target: 75%)</td>
<td>60.0%</td>
<td>54.0%</td>
<td>31.0%</td>
<td>66.0%</td>
<td>73.0%</td>
<td>75.0%</td>
<td>78.0%</td>
<td>84.0%</td>
<td>86.0%</td>
<td>88.0%</td>
<td>80.0%</td>
<td>88.0%</td>
<td></td>
</tr>
<tr>
<td>Waiting Time: 18 weeks (Target: 85%)</td>
<td>80.0%</td>
<td>88.0%</td>
<td>90.5%</td>
<td>91.7%</td>
<td>99.0%</td>
<td>99.6%</td>
<td>98.9%</td>
<td>99.9%</td>
<td>99.9%</td>
<td>99.9%</td>
<td>99.2%</td>
<td>99.7%</td>
<td>99.8%</td>
</tr>
</tbody>
</table>

### Lewisham Dementia Diagnosis

<table>
<thead>
<tr>
<th>Month</th>
<th>Dec</th>
<th>Jan</th>
<th>Feb</th>
<th>Mar</th>
<th>Apr</th>
<th>May</th>
<th>Jun</th>
<th>Jul</th>
<th>Aug</th>
<th>Sep</th>
<th>Oct</th>
<th>Nov</th>
<th>Dec</th>
</tr>
</thead>
<tbody>
<tr>
<td>Monthly referrals to and within the Trust</td>
<td>914</td>
<td>911</td>
<td>911</td>
<td>914</td>
<td>908</td>
<td>917</td>
<td>920</td>
<td>916</td>
<td>918</td>
<td>943</td>
<td>1947</td>
<td>1954</td>
<td>1957</td>
</tr>
<tr>
<td>Number of referrals</td>
<td>326</td>
<td>320</td>
<td>321</td>
<td>323</td>
<td>328</td>
<td>321</td>
<td>324</td>
<td>321</td>
<td>328</td>
<td>322</td>
<td>324</td>
<td>321</td>
<td>323</td>
</tr>
<tr>
<td>Recovery rate</td>
<td>57.4%</td>
<td>57.3%</td>
<td>57.8%</td>
<td>58.0%</td>
<td>58.7%</td>
<td>57.8%</td>
<td>58.1%</td>
<td>58.0%</td>
<td>58.7%</td>
<td>57.8%</td>
<td>58.1%</td>
<td>58.0%</td>
<td>58.7%</td>
</tr>
<tr>
<td>Number of referrals to and within the Trust</td>
<td>67</td>
<td>67</td>
<td>67</td>
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</tr>
<tr>
<td>Number of referrals to and within the Trust</td>
<td>372</td>
<td>373</td>
<td>373</td>
<td>372</td>
<td>372</td>
<td>373</td>
<td>374</td>
<td>373</td>
<td>374</td>
<td>376</td>
<td>378</td>
<td>378</td>
<td>373</td>
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</table>

### Lewisham Early Intervention in Psychosis

<table>
<thead>
<tr>
<th>Month</th>
<th>Dec</th>
<th>Jan</th>
<th>Feb</th>
<th>Mar</th>
<th>Apr</th>
<th>May</th>
<th>Jun</th>
<th>Jul</th>
<th>Aug</th>
<th>Sep</th>
<th>Oct</th>
<th>Nov</th>
<th>Dec</th>
</tr>
</thead>
<tbody>
<tr>
<td>Monthly 1st treatments required to achieve access target by Q4</td>
<td>587</td>
<td>587</td>
<td>587</td>
<td>587</td>
<td>644</td>
<td>644</td>
<td>644</td>
<td>587</td>
<td>587</td>
<td>587</td>
<td>664</td>
<td>664</td>
<td>664</td>
</tr>
<tr>
<td>Number of first treatments</td>
<td>316</td>
<td>301</td>
<td>433</td>
<td>380</td>
<td>462</td>
<td>547</td>
<td>532</td>
<td>626</td>
<td>520</td>
<td>570</td>
<td>743</td>
<td>310</td>
<td>378</td>
</tr>
<tr>
<td>Recovery rate (target: 50%) - Local data</td>
<td>35.0%</td>
<td>43.0%</td>
<td>44.0%</td>
<td>51.6%</td>
<td>51.0%</td>
<td>49.0%</td>
<td>47.0%</td>
<td>47.1%</td>
<td>51.4%</td>
<td>51.4%</td>
<td>48.2%</td>
<td>45.3%</td>
<td>47.2%</td>
</tr>
<tr>
<td>Published Recovery Rate</td>
<td>35.0%</td>
<td>42.0%</td>
<td>43.0%</td>
<td>47.0%</td>
<td>50.0%</td>
<td>47.0%</td>
<td>46.6%</td>
<td>48.7%</td>
<td>51.7%</td>
<td>56.0%</td>
<td>47.7%</td>
<td>tbc</td>
<td>tbc</td>
</tr>
<tr>
<td>Waiting Time: 6 weeks (Target: 75%)</td>
<td>94.0%</td>
<td>90.0%</td>
<td>88.0%</td>
<td>88.0%</td>
<td>88.0%</td>
<td>88.0%</td>
<td>88.0%</td>
<td>88.5%</td>
<td>90.0%</td>
<td>91.4%</td>
<td>92.0%</td>
<td>97.7%</td>
<td>99.5%</td>
</tr>
<tr>
<td>Waiting Time: 18 weeks (Target: 85%)</td>
<td>68.0%</td>
<td>90.0%</td>
<td>89.0%</td>
<td>90.0%</td>
<td>90.0%</td>
<td>90.0%</td>
<td>90.0%</td>
<td>91.7%</td>
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</table>

### Southwark IAPT

<table>
<thead>
<tr>
<th>Month</th>
<th>Dec</th>
<th>Jan</th>
<th>Feb</th>
<th>Mar</th>
<th>Apr</th>
<th>May</th>
<th>Jun</th>
<th>Jul</th>
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<th>Sep</th>
<th>Oct</th>
<th>Nov</th>
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<td>45.3%</td>
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<td>Published Recovery Rate</td>
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<td>47.0%</td>
<td>46.6%</td>
<td>48.7%</td>
<td>51.7%</td>
<td>56.0%</td>
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<td>tbc</td>
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</tr>
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<td>88.0%</td>
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<td>88.0%</td>
<td>88.0%</td>
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<td>88.5%</td>
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<td>90.0%</td>
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<td>90.0%</td>
<td>91.7%</td>
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<td>90.0%</td>
<td>90.0%</td>
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</tr>
</tbody>
</table>
2.1 Business Intelligence and Trust Information Developments

The Business Intelligence (BI) team continues to focus on the key information priorities, outlined by the Trust Senior Management Team. The new data outputs use up-to-date statistical, qualitative improvement and visualisations techniques, all of which are integral to the Deming information system. It is intended that the content of Deming will evolve over time, enabling each clinician to analyse their own data, and that of their peers. This will lead to a sustainable improvement to the quality of care delivered, patient outcomes and experience.

The Patient Flow Dashboard project continues to deliver against stakeholder requirements. The first release of the dashboard was piloted by Lewisham, where it was well-received. The feedback gained has helped shape the next iteration which is due to be released imminently. Other borough sites are now being scheduled to adopt the new release. Future iterations of the dashboard will include risk stratification and modelling of the patient flow throughout the entire mental health system operated by the Trust.

The next version of the Mental Health Services Data Set (version 4) is in the process of being developed, following the requirements gathering exercise. This latest version will see an improved focus on employment, carers, restrictive interventions, medication, care plans and indirect activity. The Trust will start submitting this data from May 2019 and are liaising with NHS Digital to ensure a smooth transition.

3. Operational Performance and Activity

3.1 Planning for a No Deal ‘Brexit’

The Secretary of State for Health and Social Care issued information on the Government’s revised border planning assumptions to industry and the health and care system. These letters focused on supply chain implications if the United Kingdom (UK) leaves the European Union (EU) without a ratified agreement on 29 March 2019 – a ‘no deal’ exit.

The Department of Health and Social Care, with the support of NHS England and Improvement, and Public Health England, has set up a national Operational Response Centre. This will lead on responding to any disruption to the delivery of health and care services in England, that may be
caused or affected by EU Exit. The Operational Response Centre will co-ordinate EU Exit-related information flows and reporting across the health and care system.

NHS England and Improvement will also establish local, regional and national teams to enable rapid support on emerging local incidents and escalation of issues into the Operational Response Centre as required.

The Government has drawn up an EU Exit Operational Readiness Guidance highlighting areas of significance where organisations should focus their preparation plans.

- supply of medicines and vaccines
- supply of medical devices and clinical consumables
- supply of non-clinical consumables, goods and services
- workforce
- reciprocal healthcare
- research and clinical trials
- data sharing, processing and access

A South East London Brexit planning group has been set up for which Kris Dominy, Chief Operating Officer is the SLaM representative. In addition, the COO has set up an internal task and finish group which has met 3 times since the 11th January, where the following outline plan is being implemented:

- Develop a SLaM action plan
- Undertake a risk assessment using the Trust’s BAF template
- Develop a Trust business continuity plan.

An action plan has been formulated with identified areas of risk. The Task and Finish Group meets weekly to monitor and progress all identified actions.

<table>
<thead>
<tr>
<th>NHS Ref</th>
<th>Action</th>
</tr>
</thead>
</table>
| RP.1    | Undertake an assessment of risks associated with EU Exit covering, but not limited to:  
The seven key areas identified nationally and detailed below  
Potential increases in demand associated with wider impacts of a 'no deal' exit.  
Locally specific risks resulting from EU Exit. |
| RP.2    | Continue business continuity planning in line with legal requirements under the Health and Social Care Act 2012, taking into account this guidance and working with wider system partners to ensure plans across the health and care system are robust. |
| RP.3    | Test existing business continuity and incident management plans against EU Exit risk assessment scenarios to ensure these are fit for purpose. |
| RP.4    | Liaise with Acute Trusts on Brexit preparation |
| RP.5    | Liaise with Local Authority partners on Brexit preparations |
| RP.6    | Establish Mutual Aid availability with Met Police |
| RP.7    | Establish SLaM EU National staff |
| RP.8    | Establish SLaM EU National patients |
| RP.9    | Establish EU exit contingency fund |
| RP.10   | Obtain Brexit helpline email address |
| **RP.11** | Ensure readiness of SLaM emergency control room |
| **RP.12** | Procure additional ASCOM handsets |
| **RP.13** | Stand up Emergency Preparedness Group |

| **CE.1** | The board is sighted on EU Exit preparation and take steps to raise awareness amongst staff. |
| **CE.2** | Ensure Local Health Resilience Partnerships, Local Resilience Forums and Local A&E Delivery Boards are sighted on EU Exit preparation in your local health economy. |
| **CE.3** | Review capacity and activity plans, as well as annual leave, on call and command and control arrangements around the 29 March 2019, but at this point there is no ask to reduce capacity or activity around this time. |
| **CE.4** | Be ready for further operational guidance from NHS England and Improvement as contingency planning work progresses. |
| **CE.5** | Confirm escalation routes for different types of issues potentially arising from or affected by EU Exit into the regional NHS EU Exit teams listed in this document. |
| **CE.6** | Escalate any issues you have identified as having a potentially widespread impact immediately to your regional EU Exit team. |
| **CE.7** | Confirm the organisation’s Senior Responsible Officer for EU Exit preparation and identify them to your regional EU Exit team. Identify named staff to work in a team with the Senior Responsible Officer to support EU Exit preparation, implementation and incident response. |

| **1.1** | Follow the Secretary of State’s message not to stockpile additional medicines beyond their business as usual stock levels. |
| **1.2** | Promote the Secretary of State’s message not to stockpile additional medicines beyond their business as usual stock levels. |
| **1.3** | Direct staff to promote messages of continuity and reassurance to people who use health and care services, including that they should not store additional medicines at home. |
| **1.8** | Continue to report current shortage issues and escalate queries for medicine supply issues unrelated to current shortages through existing regional communication channels. |

<p>| <strong>3.1</strong> | Continue commercial preparation for EU Exit as part of your usual resilience planning, addressing any risks and issues identified through your own risk assessments that need to be managed locally. |
| <strong>3.2</strong> | Continue to update local business continuity plans to ensure continuity of supply in a ‘no deal’ scenario. Where appropriate, these plans should be developed in conjunction with the Local Health Resilience Partnership. All health organisations should be engaged in their relevant Local Health Resilience Partnership, which should inform Local Resilience Forum(s) of local EU Exit plans for health and care. |
| <strong>3.4</strong> | Submit the results of our self-assessment on non-clinical consumables, goods and services to <a href="mailto:contractreview@dhsc.gov.uk">contractreview@dhsc.gov.uk</a>, if not done so already. |
| <strong>3.5</strong> | Act upon further guidance to be issued by the Department in January 2019. |
| <strong>3.1</strong> | Assess whether the organisation has incurred a reduction in the number of EU nationals in your workforce before the UK leaves the EU. |
| <strong>4.2</strong> | Publicise the EU Settlement Scheme to health and care staff who are EU citizens and actively support them to apply for the scheme when it opens in March 2019 |</p>
<table>
<thead>
<tr>
<th>Paragraph</th>
<th>Text</th>
</tr>
</thead>
<tbody>
<tr>
<td>4.4</td>
<td>Monitor the impact of EU Exit on our workforce regularly and develop contingency plans to mitigate a shortfall of EU nationals in the organisation, in addition to existing plans to mitigate workforce shortages. These plans should be developed with our Local Health Resilience Partnership, feed into your Local Resilience Forum(s) and be shared with your local commissioner(s). Consider the implications of further staff shortages caused by EU Exit across the health and care system, such as in adult social care, and the potential impact that would have.</td>
</tr>
<tr>
<td>4.7</td>
<td>Undertake local risk assessments to identify any staff groups or services that may be vulnerable or unsustainable if there is a shortfall of EU nationals.</td>
</tr>
<tr>
<td>4.8</td>
<td>Ensure the board has approved business continuity plans that include EU Exit workforce planning, including the supply of staff needed to deliver services.</td>
</tr>
<tr>
<td>4.1</td>
<td>Notify our local commissioner and regional NHS EU Exit Team at the earliest opportunity if there is a risk to the delivery of your contracted services.</td>
</tr>
<tr>
<td>4.11</td>
<td>Escalate concerns through existing reporting mechanisms.</td>
</tr>
<tr>
<td>4.12</td>
<td>Inform staff that health and care professionals (including UK citizens), whose qualification has been recognised and who are registered in the UK before 23:00 on 29 March 2019, will continue to be registered after this point.</td>
</tr>
<tr>
<td>4.13</td>
<td>Inform staff that health and care professionals (including UK citizens), who apply to have their qualification recognised in the UK before 23:00 on 29 March 2019, will have their application concluded under current arrangements.</td>
</tr>
<tr>
<td>5.1</td>
<td>Continue to support individuals who apply for NHS authorised treatment or maternity care in another member state (the S2 and cross-border healthcare processes).</td>
</tr>
<tr>
<td>5.2</td>
<td>Maintain a strong focus on correctly charging those who should be charged directly for NHS care.</td>
</tr>
<tr>
<td>5.4</td>
<td>Ensure there is capacity available for any further training that may be required if there are changes to the reciprocal healthcare arrangements.</td>
</tr>
<tr>
<td>6.2</td>
<td>Provide information about the Horizon 2020 grant here. This should be actioned as soon as possible. Further guidance can be found here and all queries should be sent to <a href="mailto:EUGrantsFunding@ukri.org">EUGrantsFunding@ukri.org</a>.</td>
</tr>
<tr>
<td>6.3</td>
<td>Contact officials at <a href="mailto:EU-Health-Programme@dhsc.gov.uk">EU-Health-Programme@dhsc.gov.uk</a> with information regarding any Third Health Programme grants.</td>
</tr>
<tr>
<td>6.4</td>
<td>Follow the Government’s guidance on the supply of investigational medicinal products (IMPs) for clinical trials in a ‘no deal’ scenario, if we sponsor or lead clinical trials or clinical investigations in the UK.</td>
</tr>
<tr>
<td>6.6</td>
<td>Consider supply chains for those products which originate from, or travel through, the EU and EEA as soon as possible if you sponsor or lead clinical trials or investigations in the UK.</td>
</tr>
<tr>
<td>6.8</td>
<td>Liaise with trial and study Sponsors to understand their arrangements to ensure that products which come from, or via, the EU or EEA, are guaranteed in the event of any possible border delays.</td>
</tr>
<tr>
<td>6.9</td>
<td>Respond to any enquiries to support the Department’s comprehensive assessment of the expected impact of a ‘no deal’ exit on clinical trials and investigations.</td>
</tr>
<tr>
<td>6.1</td>
<td>Continue participating in and/or recruiting patients to clinical trials and investigations up to and from 29 March 2019. This should occur unless you receive information to the contrary from a trial Sponsor, organisation managing the trial or clinical investigation, or from formal communications that a clinical trial or clinical investigation is being impacted due to trial supplies.</td>
</tr>
</tbody>
</table>
7.1 Investigate the organisation’s reliance on transfers of personal data from the EU/EEA to the UK, especially those that are critical to patient care and/or would have a serious impact upon the system if they were disrupted.

7.2 Follow the advice from The Department for Digital, Culture, Media and Sport and the ICO on data protection in a ‘no deal’ scenario, which can be viewed on gov.uk and on the ICO website, to determine where to use and how to implement standard contractual clauses.

7.3 Ensure that our data and digital assets are adequately protected by completing your annual Data Security and Protection Toolkit assessment.

7.4 Record costs (both revenue and capital) incurred in complying with this guidance. Costs with a direct financial impact should be recorded separately to opportunity costs. Discuss these costs with the regional NHS EU Exit support team. Feedback from providers will inform decisions on whether further guidance on cost collection is required.

The detailed risk assessment and the business continuity plan are attached at Appendix 1.

3.2 CAMHS Waiting Times

CAMHS waiting times, specifically children and young people continuing to wait in excess of 52 weeks for a first appointment, continues to be monitored and reported. The CAMHS Directorate has a programme in place including the weekly management huddle to oversee actions and problem solve challenges as they arise. This all contributes to eliminating long waits and ensures all staff are fully engaged and supported with this major initiative.

Commissioners have been actively engaged with this initiative and have provided non-recurrent funding in Q4. Commissioners are working with local services to develop the 2019/20 investment plans.

In response to queries at the previous Board please see below details for all young people waiting over 52 weeks for our community services:

<table>
<thead>
<tr>
<th>Weeks</th>
<th>Number Reported</th>
<th>Note</th>
</tr>
</thead>
<tbody>
<tr>
<td>Over 100 weeks</td>
<td>2</td>
<td>123 weeks (Lewisham) 119 weeks (Lewisham)</td>
</tr>
<tr>
<td>80-99 weeks</td>
<td>12</td>
<td>6 seen in last 12 months by other services</td>
</tr>
<tr>
<td>60-79</td>
<td>66</td>
<td>10 seen in last 12 months by other services</td>
</tr>
<tr>
<td>52-59</td>
<td>88</td>
<td>4 seen in last 12 months by other services</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>168</strong></td>
<td></td>
</tr>
</tbody>
</table>

There are 38 young people currently in excess of a 52 week wait with a booked appointment prior to 18th March 2019. There are 11 appointments made where the young person would tip over to 52 weeks prior to 18th March (i.e. currently 48-51 week waiters). Additional group sessions also continue to be booked within this timeframe.

Weekly review and validation of data continues to take place and a number of reporting improvements have been identified. Due to the need for cases to remain open to their local community team, there isn’t a mechanism to automatically report where the young person is being seen in T4 specialist services. Furthermore, where the case is open for CAMHS services to provide consolation on an ongoing basis this would currently register as an open wait. There has however, been an example where
the original waiting times report was only counting part of the referral wait interval and this has been corrected in the table above with a resulting increase when compared to numbers reported during 2018.

As previously reported, the largest number of long waiters is in Lewisham. The number waiting in excess of 52 weeks at the end of each month since April 2018 is shown in the following chart, with 127 waiting at the end of January.

![Chart showing numbers of patients waiting over 52 weeks](chart.png)

Fig. 1 - Young people in Lewisham waiting over 52 weeks at the end of the month Apr – Jan 2019

The restated data has changed the profile of waits for the other boroughs and the borough with the next highest number of young people waiting over 52 weeks is Croydon where 25 young people were waiting at the end of January.

During February, the Lewisham system (i.e. local authority, CCG, voluntary sector and SLaM CAMHS partners) received support from NHSI and a report is being compiled with a range of actions and improvement proposals. Internally, the CAMHS Directorate has asked for support from the QI team and the Director of Transformation to assist the service in quantifying their demand, capacity and trajectories to be able to set out the timescale for the long wait recovery plan. This information also supports the on-going discussion across both STPs regarding CAMHS access.

NELFT has advised that delays in the NHSE commissioner response subsequent to the November 2018 meeting has placed the 1st April transfer of Kent services at risk. SLaM is working closely with NELFT colleagues to understand the commissioners plan to enact the transfer and service funding.
3.3 Length of Stay

With the 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 21 months is 50 days against our target of 32 Days).

Croydon  
Lambeth

Lewisham  
Southwark

Figs1a: Trust LoS Data from Power BI Trust Dashboard - inpatient wards

3.4 Patient Flow Plan

To deliver on length of stay targets and other key metrics for in-patient wards the Trust continues to implement its agreed Flow Plan. With a reduction in 12 hour breaches and positive feedback from all local Acute Trust Partners and A&E Delivery Boards on SLaM Liaison Services, the delivery focus continues on reducing private sector placements. The COO has set up daily calls with all four Borough Service Directors to assure delivery on reducing private overspill and keeping patients as close to home as possible. All this work is linked to ensuring the correct level of community capacity is commissioned to reduce reliance on bed based services. This work is being taken forward with commissioners via the 2019/20 contract negotiations to ensure funding is in place to increase community team capacity. The Board received a report on this work in train to increase community capacity at a previous meeting.

Current private sector usage (including the use of Flow Plan ELFT beds) is set out below:
The four key performance indicators that are measuring the overall effectiveness of the plan and their reported status are set out below (noting the Mental Health Act Cancellation numbers are a first cut and going through an internal validation review at the time of report submission):

![Dec 18 data chart]

![Jan 19 data chart]

An automated ‘Daily Dashboard’ has also been developed so the Trust Senior Leadership have access to live information on admission, discharge and private sector usage to ensure ownership and line of sight on performance.

### 3.3 Community Activity & Performance

There is persistent increasing pressure in most areas of the community system. 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 at M10, January 2019. Lewisham CAMHS remains at the highest level of waits over 12 months at 189 patients at the time of reporting; a reduction from the 209 patients reported in January’s report. Croydon and Southwark Personality Disorders and Psychological Therapies waiting times have increased marginally to 147 and 162 patients respectively.

<table>
<thead>
<tr>
<th>Patients still Waiting (over 12 months) 2018/19</th>
</tr>
</thead>
<tbody>
<tr>
<td>CAG</td>
</tr>
<tr>
<td>Acute Care Pathway</td>
</tr>
<tr>
<td>Addictions</td>
</tr>
<tr>
<td>Child and Adolescent Mental Health Services</td>
</tr>
<tr>
<td>MIHA and Dementia</td>
</tr>
<tr>
<td>Psychological Medicine &amp; Integrated Care</td>
</tr>
<tr>
<td>Psychosis</td>
</tr>
<tr>
<td><strong>Total</strong></td>
</tr>
<tr>
<td>Croydon</td>
</tr>
<tr>
<td>Lambeth</td>
</tr>
<tr>
<td>Lewisham</td>
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<tr>
<td>Southwark</td>
</tr>
<tr>
<td><strong>Total</strong></td>
</tr>
</tbody>
</table>

Figs1b: Patients waiting over 12 months at December 2018. Trust Waiting Times Data from Power BI Trust Data App. (Download 2nd week February 2019)
A detailed piece of work is underway to review wait times for community services across all boroughs linked to the community redesign work in train outlined in a separate Board Report on the Agenda. This work also form part of preparation plans for the upcoming CQC inspection. The Board received at its last meeting a copy of Community Quest Data for December, including waiting times per borough, and this can be redistributed again for January if helpful to Board Members. This information can also be accessed ‘live’ via Deming (the Trust Dashboard).

4. Updates from Our Improvement Plan Meetings and Performance and Quality Meetings

The latest round of Performance and Quality (P&Q) meetings are being scheduled for late February with outcomes and areas of escalation to be reported to the next Board Meeting. The same dataset that is used to inform this Board Report will be reviewed by the P&Q meetings to ensure the golden thread of Floor to Board Reporting.

The Delivery Board for our Improvement Plan will meet on 20th February and Oversight and Scrutiny Group will meet on 21st February. Areas of escalation will be reported verbally to Board.

5.1 Mandatory Training Compliance

Compliance has continued to fall from 85.07% to 84.55%, thus making the Trust non-compliant in mandatory training overall.

5.1.1 Current compliance rates

Due to the Mental Health Law Committee agreement in April 2018 to change audiences for Mental Health Capacity Act (MCA) Levels 1 & 2 and Deprivation of Liberty (DoLs) training the pool of those required to complete had widened. This has impacted the figures for compliance for these courses when updates were made in December on LEAP per the committee agreement, showing a reduction in completions. Although compliance for this topic has improved slightly during January (66.04% up to 69.40%), the improvement was insufficient to prevent the negative impact on overall compliance. The issue has been flagged by E&D to the Associate HR Director and MH Law committee, who have agreed that these audiences will be revisited and all future audience changes for mandatory training will be signed off by the Senior Management Team before implementation. It is anticipated this will be rectified by next month and figures will be corrected to show improved compliance figures.

Current compliance by directorate and by subject matter is shown in Appendices document.

5.1.2 Specific actions in relation to current areas of concern

PSTS Disengagement

We saw a downward trend in January for both Disengagement (74.25% down to 70.79%) and PSTS Awareness (theory only) (86.81% down to 83.84%), despite delivering training to larger cohorts at the Ortus. As we have now moved all of our Disengagement training to the Ortus, we are able to offer a further 24-30 delegate places per month. This brings further training opportunities for staff for this course, however continual issues of cancellation and DNAs could hamper improvements. It is recommended that the Board and Senior Management Team underline to all managers and staff that cancellations and DNAs for mandatory training should be avoided unless there is a valid reason.

As we are no longer delivering this training at Lambeth and Bishopsgate Training Centres, we have adjusted the start time for the course to 10.00 am to flexibility and accessibility to accommodate all delegates who may have to travel further to the Ortus. We are also hoping that if staff cancel on the day, the later start time will enable managers to send another member of staff to attend training to minimise DNAs.
**Resuscitation Training**

There has been a minimal improvement in Immediate Life Support training this month.

In an effort to counteract the impact DNA's have on this training, we are in negotiations with the external training company providing the Advanced Life Instructor, co-facilitating ILS training with SLaM tutors, trial overbooking the session by one delegate to mitigate against lower numbers. As this is a Resuscitation Council (UK) certificated course, the delegate to tutor ratio is strictly governed to 2 trainers to 6 delegates and if the overbooking trial results in exceeding this ratio on a regular basis the overbooking approach shall cease. The optimum solution would be to have a reduction in late cancellations and DNAs. It is noted that since autumn 2017 there have been no charges to teams for DNAs.

Basic Life Support compliance for clinical staff has dropped but we have recently trained eight in-house BLS tutors, three of whom are service users. These new trainers will be used to deliver BLS with more experienced trainers and we anticipate an improvement in compliance in the coming months.

**Infection Control level 2, Mental Capacity Act, Mental Health Act**

We shall continue to send individual emails to staff who are non-compliant in this training in an effort to encourage them to complete the training.

It has been noted however that the current eLearning courses from Skills for Health are too generic rather than specific to a mental health setting and this may be contributing to staff motivation to complete the courses.

Discussion is underway with the SLaM Infection Control subject matter expert to develop an MH specific learning plan and scope the cost to the Trust in developing our own courses, as this would take considerable staff capacity to complete.

6. **Commissioning and Contracting**

The 2019/20 contract negotiations are moving at pace with the offer of a 6% uplift across all CCG contracts (including Croydon); with the parallel transfer of Commissioning Budgets and Functions into a provider quality and commissioning hub during 2019/20 (also included as a separate paper to initiate discussions and planning). The Executive Team is now reviewing 2019-21 priorities for investments linked to these new developments.

The NHSE offer from Specialised Commissioning is a 3.85% uplift for the Trust against a Commissioner uplift of 8.7%. The Trust has asked for a 8.7% uplift based on this being a pass through of monies linked to meeting the Mental Health Investment Standard (i.e. not a negotiation).

The Southwark Council reduction of its adult placements budget, without partner consultation, in 2018/19 by £1m from £3.1m to £2.1 million continues to present a risk if the Council were to not pay its invoices. The Trust is working with the Council to mitigate this risk. The current risk sits at £1m+. CCG and Council commissioners have given verbal assurance all activity will be paid for.

6.1 **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.
6.2 Commissioning Programmes 2018-19
2018-19 QIPP and CQUIN schemes are being managed using the PMO principles.

6.2.2 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>2,526</td>
</tr>
<tr>
<td>Amber</td>
<td>Requires some work</td>
<td>2,902</td>
</tr>
<tr>
<td>Green</td>
<td>Requires little work</td>
<td>3,076</td>
</tr>
<tr>
<td>Total</td>
<td></td>
<td>8,504</td>
</tr>
</tbody>
</table>

The QIPP position at month 9 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 are being monitored in the monthly performance management meetings. All QIPPs are mapped to the new organisational structure.

Trust position is that all QIPP is a commissioner risk and with the Trust being responsible for CIP

QIPP Red risks

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

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

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

- **SHARP. Value £400k.** £400k QIPP & £133k CIP removed from annual budget. However, M7 budget confirms variance of £91k (Increased from £49k in M6). This will be managed via PACMAN and recovery action plan is being drafted by the new Service Director for Southwark.

- **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.

Amber Risks

- **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

- **Croydon Adult inpatient baseline as per 17/18** This QIPP is amber because of overspending against the baseline by £181k

6.2.3 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. Trust is still waiting for confirmation of Quarter 2 achievement from commissioners, which is now being escalated to the Trust’s Director of Performance and Contracts for action. Q3 submissions were successfully made at the end of January 2019 and we are also awaiting commissioner decision on the achievement for Quarter 3.

7. Emergency Preparedness Resilience and Response Assurance (EPRR)

SLAM has been formally assessed by the NHS England EPRR Network to have achieved a level of compliance of PARTIALLY COMPLIANT (AMBER).

Amber ratings were received for the following core standards:

- 30 – Incident Co-ordination Centre
- 51 – Business Continuity Plans
- 52 – Business Continuity Management System Monitoring and evaluation
- 53 – Business Continuity audit
- 54 – Business Continuity Management System continuous improvement process

Red ratings were received for the following core standards:

- 25 – Trained on call staff
- 26 – EPRR training
- 28 – Strategic and tactical responder training
- 32 – Management of business continuity incidents
- 33 – Loggist
- 47 – Business Continuity policy statement
- 48 – Business Continuity Management System scope and objectives

These are being addressed via the Trust wide action plan for 2019 and the Trust continues to make good progress on this.

8. Conclusion

The Trust continues to meet the NHS Improvement Single Oversight Framework indicators covered by this report.

Pressure across the adult acute pathway (inpatient and community) has increased and is resulting in continued usage of external overspill inpatient beds. The Flow Plan is starting to address this by creating additional capacity by increasing discharge levels, particularly in Lambeth which has seen a reduction in the use of external overspill in January 2019.

Delivery of the CQC ‘Our Improvement Plan’ continues with work underway to now measure the quality impact of the work that has been undertaken across the four boroughs and preparation for the upcoming CQC inspection of Community Services is underway.
<table>
<thead>
<tr>
<th>Abbreviation</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>AEP</td>
<td>Accountable Emergency Officer</td>
</tr>
<tr>
<td>AfC</td>
<td>Agenda for Change</td>
</tr>
<tr>
<td>Ascom</td>
<td>Alarm / communications system supplied by Ascom UK, a telecommunications company</td>
</tr>
<tr>
<td>ASD / LD</td>
<td>Autism Spectrum Disorder / Learning Disability</td>
</tr>
<tr>
<td>CAG</td>
<td>Clinical Academic Group – bringing together clinical services, research and education and training into a single management grouping e.g. Psychosis</td>
</tr>
<tr>
<td>CAMHS</td>
<td>Child and Adolescent Mental Health Services</td>
</tr>
<tr>
<td>CBT</td>
<td>Cognitive Behavioural Therapy (CBTp is CBT of psychosis)</td>
</tr>
<tr>
<td>CCG</td>
<td>Clinical Commissioning Group – an NHS body responsible for the planning and commissioning of health services for their local area</td>
</tr>
<tr>
<td>CHS</td>
<td>Croydon Health Services NHS Trust</td>
</tr>
<tr>
<td>CIP</td>
<td>Cost Improvement Programme</td>
</tr>
<tr>
<td>CPA</td>
<td>Care Programme Approach</td>
</tr>
<tr>
<td>CQUIN</td>
<td>Commissioning for Quality and Innovation: A fund where payment is contingent on delivery on quality improvements and meeting milestones agreed with commissioners.</td>
</tr>
<tr>
<td>CYP</td>
<td>Children &amp; Young People</td>
</tr>
<tr>
<td>DBT</td>
<td>Dialectical Behaviour Therapy</td>
</tr>
<tr>
<td>DTOC</td>
<td>Delayed Transfers of Care</td>
</tr>
<tr>
<td>E&amp;D</td>
<td>Education &amp; Development Department</td>
</tr>
<tr>
<td>EI</td>
<td>Early Intervention: First Episode Psychosis</td>
</tr>
<tr>
<td>ePJS</td>
<td>Electronic Patient Journey System: Clinical records system</td>
</tr>
<tr>
<td>EPM</td>
<td>Emergency Planning Manager</td>
</tr>
<tr>
<td>EPRR</td>
<td>Emergency Preparedness, Resilience and Response</td>
</tr>
<tr>
<td>GSTT</td>
<td>Guys &amp; ST Thomas’ NHS Foundation Trust</td>
</tr>
<tr>
<td>HTT</td>
<td>Home Treatment Team</td>
</tr>
<tr>
<td>IAPT</td>
<td>Improving Access to Psychological Therapies</td>
</tr>
<tr>
<td>JOSC</td>
<td>Joint Overview and Scrutiny Committee</td>
</tr>
<tr>
<td>LoS</td>
<td>Length of Stay. The duration of an inpatient stay, usually measured in days. Can include or exclude leave and can focus on a stay on a particular ward or the full hospital admission.</td>
</tr>
<tr>
<td>LSLC</td>
<td>Lambeth, Southwark, Lewisham &amp; Croydon (CCGs)</td>
</tr>
<tr>
<td>LTC</td>
<td>Long Term Condition</td>
</tr>
<tr>
<td>MHOAD</td>
<td>Mental Health of Older Adults and Dementia</td>
</tr>
<tr>
<td>MHSDS</td>
<td>Mental Health Services Data Set: National dataset submitted to NHS Digital (formerly known as the Health &amp; Social Care Information Centre)</td>
</tr>
<tr>
<td>NHSE</td>
<td>NHS England</td>
</tr>
<tr>
<td>NHSE(L)</td>
<td>NHS England (London)</td>
</tr>
<tr>
<td>NHSI</td>
<td>NHS Improvement: the new regulatory body overseeing all NHS providers as well as independent providers that provide NHS funded care</td>
</tr>
<tr>
<td>NHSP</td>
<td>NHS Professionals</td>
</tr>
<tr>
<td>Abbreviation</td>
<td>Description</td>
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<td>--------------</td>
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</tr>
<tr>
<td>NICE</td>
<td>National Institute for Health and Care Excellence: provides national guidance and advice to improve health and social care</td>
</tr>
<tr>
<td>OAP</td>
<td>Out of Area Placement</td>
</tr>
<tr>
<td>OBD</td>
<td>Occupied Bed Day – is a unit of currency used to measure the use made of a bed (e.g. 1 obd = 1 bed occupied for 1 day by a patient)</td>
</tr>
<tr>
<td>PACMAN</td>
<td>Performance and Contract Management (meeting)</td>
</tr>
<tr>
<td>PICU</td>
<td>Psychiatric Intensive Care Unit</td>
</tr>
<tr>
<td>PMF</td>
<td>Performance Management Framework</td>
</tr>
<tr>
<td>PMO</td>
<td>Programme Management Office</td>
</tr>
<tr>
<td>QIA</td>
<td>Quality Impact Assessment</td>
</tr>
<tr>
<td>QIPP</td>
<td>Quality, Innovation, Productivity and Prevention programme is a series of schemes required by the CCGs and developed with SLaM to help enhance services and improve their cost effectiveness</td>
</tr>
<tr>
<td>QuESTT</td>
<td>Quality, Effectiveness and Safety Trigger Tool. An inpatient self-audit which enables pressures in inpatient wards to be quantified. In 2018 a simple community equivalent is being developed and introduced at SLaM.</td>
</tr>
<tr>
<td>SEL</td>
<td>South East London</td>
</tr>
<tr>
<td>SLP</td>
<td>South London Mental Health and Community Partnership. A partnership of SLaM, Oxleas and SWLStG formed in 2015</td>
</tr>
<tr>
<td>SOF</td>
<td>Single Oversight Framework: NHSI assurance and performance mechanism</td>
</tr>
<tr>
<td>SPC</td>
<td>Statistical Process Control</td>
</tr>
<tr>
<td>STP</td>
<td>Sustainability and Transformation Partnership</td>
</tr>
<tr>
<td>SWL</td>
<td>South West London</td>
</tr>
<tr>
<td>SWLStG</td>
<td>South West London and St George’s Mental Health NHS Trust</td>
</tr>
<tr>
<td>YTD</td>
<td>Year to Date</td>
</tr>
</tbody>
</table>
**Principal Risk (No deal exit from the EU on March 29th 2019)** Under the current arrangements for contracts, supplies, EU citizens resident in the UK, information sharing/storage and clinical trials and in the event of a no deal scenario exit from the EU could impact on delays in supplies, workforce, service users, information governance and financial controls/funding.

<table>
<thead>
<tr>
<th>Owner: KD COO</th>
<th>Initial</th>
<th>Current</th>
<th>Target</th>
</tr>
</thead>
<tbody>
<tr>
<td>Committee: EU Exit Committee</td>
<td>4</td>
<td>4</td>
<td>4</td>
</tr>
<tr>
<td>Proximity: 6-9 months</td>
<td>4</td>
<td>4</td>
<td>2</td>
</tr>
<tr>
<td>Risk Category: Quality</td>
<td>16</td>
<td>16</td>
<td>8</td>
</tr>
<tr>
<td>Risk Appetite: Cautious (nominal range 3-8)</td>
<td></td>
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</tr>
<tr>
<td><strong>Potential Causes (links to the CRR)</strong></td>
<td></td>
<td></td>
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</tr>
<tr>
<td>Preparation: Unidentified risks, poor planning.</td>
<td></td>
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<tr>
<td>Service users: Application for visa's if applicable, emotional stress, anxiety and misinformation.</td>
<td></td>
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<tr>
<td>Supplies: Delays in pharmaceuticals, clinical and non clinical consumables.</td>
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<td></td>
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</tr>
<tr>
<td>Data sharing, processing and access: Breaches in information governance legislation and impact on access to clinical information.</td>
<td></td>
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<tr>
<td>Clinical trials: Impact on funding.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Finance: Increased cost pressure</td>
<td></td>
<td></td>
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</tr>
<tr>
<td><strong>Potential Consequences</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Lack of leadership and co-ordination could create significant gaps in controls and identified risks.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Not assessing the risks to the organisation in the eventuality of a no deal could leave the Trust exposed and impact on service delivery.</td>
<td></td>
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<td></td>
</tr>
<tr>
<td>Failure to adequately prepare for EU Exit and formulate business continuity plans.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Failure to test and exercise business continuity plans and identify gaps/resilience.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Assumptions regarding partner organisations plans and how this may or may not affect Slam.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Reliance on emergency services in the event of untoward incident, increased MHA A3's, 135's and ongoing support.</td>
<td></td>
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<td></td>
</tr>
<tr>
<td>Anxiety and uncertainty amongst staff.</td>
<td></td>
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<tr>
<td>Generation of rumours and mixed messages.</td>
<td></td>
<td></td>
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</tr>
<tr>
<td>Delays in cross border shipping of ascom handsets which could impact on staff safety.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Unclear lines of escalation.</td>
<td></td>
<td></td>
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<tr>
<td>Breaches of statutory compliance.</td>
<td></td>
<td></td>
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</tr>
<tr>
<td>Lack of knowledge and assessment of supply chains and contractors.</td>
<td></td>
<td></td>
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</tr>
<tr>
<td>Reduction in workforce which could impact on staff and patient safety.</td>
<td></td>
<td></td>
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</tr>
<tr>
<td>Impact on operational delivery.</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Identified and designated executive board member as SOR.
Formulation of a core group.
Formulation of a senior EU Exit group to meet regularly and update all members on actions taken.
Undertake an assessment of risks associated with EU Exit covering, but not limited to:
The seven key areas identified nationally.
Potential increases in demand associated with wider impacts of a ‘no deal’ exit.
Locally specific risks resulting from EU Exit.
Create business continuity planning in line with our legal requirements under the Health and Social Care Act 2012, taking into account this guidance and working with wider system partners to ensure plans across the health and care system are robust.
Test existing business continuity and incident management plans against EU Exit risk assessment scenarios to ensure these are fit for purpose.
Liaise with Acute Trusts on Brexit preparation.
Liaise with Local Authority partners on Brexit preparations.
Establish Mutual Aid availability with Met Police.
Establish SLaM EU National staff.
Establish SLaM EU National patients.
Establish EU exit contingency fund.
Obtain Brexit helpline email address.
Ensure readiness of SLaM emergency control room.
Procure additional ASCOM handsets.
Stand up Emergency Preparedness Group.
Ensure the board is sighted on EU Exit preparation and take steps to raise awareness amongst staff.
Ensure Local Health Resilience Partnerships, Local Resilience Forums and Local A&E Delivery Boards are sighted on Slam EU Exit preparation.
Review capacity and activity plans, as well as annual leave, on call and command and control arrangements around the 29 March 2019, but at this point there is no ask to reduce capacity or activity around this time.
Be ready for further operational guidance from NHS England and Improvement as contingency planning work progresses.
Confirm escalation routes for different types of issues potentially arising from or affected by EU Exit into the regional NHS EU Exit teams.
Follow the Secretary of State’s message not to stockpile additional medicines beyond their business as usual stock levels.

Key Controls

Gaps in Control

No previous history of a no deal Eu Exit to benchmark potential risks.
No evidence of business continuity plans include scenarios for a no deal EU Exit.
Met Police have cancelled all leave in anticipation of demonstrations/unrest, potential impact on support to Slam.
Use of NHSP/Agency staff is widespread and Slam do not have controls on this staffing group.
Assurance from external suppliers and contractors untested.
Directive to staff is no leave to be carried forward, resulting in increased leave arrangements for March 2019.
Identified cost centre for ascom handsets.
No centralised/overarching business continuity plan for a no deal EU Exit.
<table>
<thead>
<tr>
<th>Sources of Assurance</th>
</tr>
</thead>
<tbody>
<tr>
<td>Chief Operating Officer,</td>
</tr>
<tr>
<td>PMO,</td>
</tr>
<tr>
<td>EPRR Leads,</td>
</tr>
<tr>
<td>Emergency Preparedness Group,</td>
</tr>
<tr>
<td>EU Exit working group,</td>
</tr>
<tr>
<td>Pharmacy,</td>
</tr>
<tr>
<td>Information governance,</td>
</tr>
<tr>
<td>Human Resources,</td>
</tr>
<tr>
<td>Clinical Leads,</td>
</tr>
<tr>
<td>Medical Director,</td>
</tr>
<tr>
<td>Communications,</td>
</tr>
<tr>
<td>Procurement,</td>
</tr>
<tr>
<td>Contractors,</td>
</tr>
<tr>
<td>Suppliers,</td>
</tr>
<tr>
<td>E&amp;F,</td>
</tr>
<tr>
<td>Business Continuity plan,</td>
</tr>
<tr>
<td>EU Exit BAF Risk assessment,</td>
</tr>
<tr>
<td>Frequent EU Exit Group meetings,</td>
</tr>
<tr>
<td>Updates and information from health partners.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Gaps in Assurance</th>
</tr>
</thead>
<tbody>
<tr>
<td>NHSP and Agencies data regarding identified EU Nationals yet to report to the Trust.</td>
</tr>
<tr>
<td>Identified members to the workforce whose relatives/family members affected by a no deal scenario.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Action plan progress summary</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Request for Closure</th>
</tr>
</thead>
</table>
REPORT TO THE CQRG  
20 FEBRUARY 2019

<table>
<thead>
<tr>
<th>Title</th>
<th>SLaM no-deal Brexit preparations</th>
</tr>
</thead>
<tbody>
<tr>
<td>Author</td>
<td>Greg Marshall</td>
</tr>
<tr>
<td>Accountable Director</td>
<td>Kris Dominy</td>
</tr>
</tbody>
</table>

Purpose of the paper

To update the CQRG on SLaM’s business continuity planning in the event of a no-deal Brexit, 29th March 2019

Executive summary

No-deal Brexit plans drawn up by DHSC require a SLaM business continuity response under the following headings: Readiness & Preparations, Communications & Escalation, and 7 distinct operational themes.

A SE London Brexit planning group has been set up for which Kris Dominy is the SLaM representative. In addition, she has set up an internal task and finish group which has met 3 times since the 11th January, where the following outline plan is being implemented:

* Develop a SLaM action plan
* Undertake a risk assessment using the Trust’s BAF template
* Develop a Trust business continuity plan.

The risk assessment and the business continuity plan are attached.

An update of the current situation will be provided at the meeting.
UK is due to leave the European Union on March 29th at 23.00. There has been no agreement between both parties. In the event the UK leaves the EU without a deal this could significantly impact on supplies entering the UK.
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FOREWORD

This plan provides details of the Trust’s response to a no deal scenario if the UK leaves the EU on March 29th 2019. The following internal departments were consulted in the production of this plan and to provide feedback:

<table>
<thead>
<tr>
<th>Emergency Preparedness Group members</th>
<th>EU Exit Group</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
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<tr>
<td></td>
<td></td>
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</tbody>
</table>

The following external partners were contacted during the production of this plan for advice, and accuracy checking:

<table>
<thead>
<tr>
<th>NHS England</th>
</tr>
</thead>
<tbody>
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<td></td>
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</tbody>
</table>

RELATED DOCUMENTS

This plan should be read in conjunction with the following associated documents, which may be implemented in the Trust’s response to a no deal EU Exit:

Internal
- Trust Incident Response Plan
- Trust Business Continuity Plan
- Departmental Business Continuity Plans
- Communications Plan
- Copy of SLaM EPRR BAF Risk Register EU Exit
- Copy of SLaM Brexit Group Actions

External
- EU Exit Operational Readiness Guidance
- EU Exit operational readiness guidance cover letter

DISTRIBUTION
This plan will be made available on the intranet for all staff to access. It will also be made available in paper form within the Emergency control rooms. Upon ratification, this plan will be distributed directly to:

**Internal**

<table>
<thead>
<tr>
<th>EU Exit Group</th>
<th>Communications Team</th>
</tr>
</thead>
<tbody>
<tr>
<td>HR</td>
<td>On Call Directors</td>
</tr>
<tr>
<td>Chief Pharmacist</td>
<td>Emergency Preparedness Group</td>
</tr>
<tr>
<td></td>
<td>members</td>
</tr>
<tr>
<td>On Call Managers</td>
<td></td>
</tr>
<tr>
<td>Occupational Health</td>
<td></td>
</tr>
<tr>
<td>Estates</td>
<td></td>
</tr>
</tbody>
</table>

**External**

| NHS England (London)   |                              |
| Clinical Commissioning Groups |                         |

**Training & Exercising**

All relevant staff within the trust are responsible for familiarising themselves with the EU Exit plan, their role and other plans that link to it. A range of exercises will be designed to rehearse and test specific elements of the Plan and to ensure that its content is both appropriate and relevant.

Training will be provided via the on-call Director and on-call manager training package.

**MAINTENANCE AND REVIEW**

This plan is managed by the Emergency Preparedness Group and EU Exit Group, reviewed following lessons learned from incidents and exercises.

1. **INTRODUCTION**

All NHS Organisations are required to plan for disruptions to services caused by a no deal EU Exit. Increased service demands, disruption to supplies and reduced staffing levels may impact upon the Trust’s ability to continue providing critical services whilst maintaining high standards of patient care.

This plan intends to give specific guidance and instruction necessary to manage disruptions to the Trust because of a no deal EU Exit.

1.1 **Aim**

The aim of this plan is to detail the arrangements to be implemented by South London and Maudsley NHS Trust in response to a no deal EU Exit.

1.2 **Objective**
The main objectives of this Plan and for the Trust during a no deal EU Exit Incident are to detail the arrangements for:

- Implementing a flexible, precautionary and proportionate response.
- Ensuring that essential activities are maintained.
- Management of the incident through the EU Exit Group.
- Providing timely, authoritative and up-to-date information to service users, staff and partner agencies.
- Return to normal working as rapidly and effectively as possible.

1.3 Risk Assessment

A risk assessment has been undertaken to evaluate the risk of a no deal EU Exit impacting on South London and Maudsley NHS Trust, based on worst case scenarios:

<table>
<thead>
<tr>
<th>Risk Ref</th>
<th>Specialty</th>
<th>Description of risk</th>
<th>Likelihood</th>
<th>Impact</th>
<th>Likelihood</th>
<th>Impact</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>3.0 No Deal Scenario if the UK Leave the EU - Staff affected and unable to attend work. Disruption to services and supply chain. Breaches of Information Governance Legislation.</td>
<td>27</td>
<td>4</td>
<td>2</td>
<td>2</td>
</tr>
</tbody>
</table>

The rating above is the Trust’s own rating, considering the impact on the Trust itself and the likelihood in terms of day to day issues. It has been agreed that even with measures in place, such as this plan, a no deal EU Exit is uncertain and unchartered waters so the risk remains high.

1.3.1 Risk Reduction

There are several potential impacts that may result from a no deal EU Exit and must be managed prior to incidents through business continuity arrangements and during the incident including:

<table>
<thead>
<tr>
<th>Issue</th>
<th>Potential impacts</th>
</tr>
</thead>
<tbody>
<tr>
<td>Increased Service Demands</td>
<td>- Period of anxiety and uncertainty may impact on mental health.</td>
</tr>
<tr>
<td></td>
<td>- Impact on Emergency Services may disrupt assessments and support from Emergency Services.</td>
</tr>
<tr>
<td></td>
<td>- Increased workload within the hospital and community due to increased assessments and referrals.</td>
</tr>
<tr>
<td>Loss of Staff</td>
<td>Supply of external products and services</td>
</tr>
<tr>
<td>------------------------------------------------------------------------------</td>
<td>-------------------------------------------------------------------------------</td>
</tr>
<tr>
<td>• EU registered staff affected due to loss of rights to reside in the UK.</td>
<td>• Inability of suppliers to deliver consumables or services, e.g.</td>
</tr>
<tr>
<td>• Staff affected because relatives have lost rights to reside in the UK.</td>
<td>equipment maintenance or deliveries.</td>
</tr>
<tr>
<td>• Increased staff absence because of care-providing responsibilities, i.e.</td>
<td>• Reduced production levels or supply chains of essential</td>
</tr>
<tr>
<td>school closures.</td>
<td>goods, e.g. pharmaceuticals, blood and blood related products or road fuel.</td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>

2 EU Exit Operational Readiness Guidance

The EU Exit Operational Readiness Guidance summarises the Government’s contingency plans and covers actions that all health and adult social care organisations should take in preparation for EU Exit.

All organisations receiving this guidance are advised to undertake local EU Exit readiness planning, local risk assessments and plan for wider potential impacts. In addition, the actions in this guidance cover seven areas of activity in the health and care system that the Department of Health and Social Care is focussing on in its ‘no deal’ exit contingency planning:

• supply of medicines and vaccines;
• supply of medical devices and clinical consumables;
• supply of non-clinical consumables, goods and services;
• workforce;
• reciprocal healthcare;
• research and clinical trials; and
• data sharing, processing and access.

The impact of a ‘no deal’ exit on the health and adult social care sector is not limited to these areas, and the Department is also developing contingency plans to mitigate risks in other areas. For example, the Department is working closely with NHS Blood and Transplant to co-ordinate ‘no deal’ planning for blood, blood components, organs, tissues and cells.

In preparation for a ‘no deal’ exit, the Department, with the support of NHS England and Improvement, and Public Health England, has set up a national Operational Response Centre. This will lead on responding to any disruption to the delivery of health and care services in England, that may be caused or affected by EU Exit. The Operational Response Centre will co-ordinate EU Exit-related information flows and reporting across the health and care system. The Operational Response Centre will also work with the devolved administrations to respond to UK-wide incidents.

The Operational Response Centre has been established to support the health and care system to respond to any disruption, and will not bypass existing local and regional reporting structures.
Working closely with the Operational Response Centre, NHS England and Improvement will also establish an Operational Support Structure for EU Exit. This will operate at national, regional and local levels to enable rapid support on emerging local incidents and escalation of issues into the Operational Response Centre as required. Contact details for the regional EU Exit leads are below:

<table>
<thead>
<tr>
<th>Region</th>
<th>Contact details for regional EU Exit lead</th>
</tr>
</thead>
<tbody>
<tr>
<td>North East</td>
<td><a href="mailto:England.euexitnortheast@nhs.net">England.euexitnortheast@nhs.net</a></td>
</tr>
<tr>
<td>North West</td>
<td><a href="mailto:England.euexitnorthwest@nhs.net">England.euexitnorthwest@nhs.net</a></td>
</tr>
<tr>
<td>Midlands</td>
<td><a href="mailto:England.mids-euexit@nhs.net">England.mids-euexit@nhs.net</a></td>
</tr>
<tr>
<td>East of England</td>
<td><a href="mailto:England.eoe-euexit@nhs.net">England.eoe-euexit@nhs.net</a></td>
</tr>
<tr>
<td>London</td>
<td><a href="mailto:England.london-euexit@nhs.net">England.london-euexit@nhs.net</a></td>
</tr>
<tr>
<td>South East</td>
<td><a href="mailto:England.se-euexit@nhs.net">England.se-euexit@nhs.net</a></td>
</tr>
<tr>
<td>South West</td>
<td><a href="mailto:England.sw-euexit@nhs.net">England.sw-euexit@nhs.net</a></td>
</tr>
</tbody>
</table>

NHS providers and commissioners will be supported by local NHS teams to resolve issues caused or affected by EU Exit as close to the frontline as possible. These issues will be escalated to regional level, as required. Where issues are impacting across the health and care system at a national level, the Operational Response Centre will co-ordinate information flows and responses.

This guidance and the planning assumptions within it represent the most up to date information available. Further operational guidance will be issued and updated to support the health and care system to prepare for the UK leaving the EU prior to 29 March 2019.

2.1 Summary

This section summarises seven areas where the government is focussing ‘no deal’ exit contingency planning in the health and care system, and where local action is required.

Common to all of the groups of medical products listed below, it should be noted that government departments have also been working to design customs and other control arrangements at the UK border to ensure goods, including medical supplies, can continue to flow into the UK without being delayed by additional controls and checks.

However, the EU Commission has made clear that, in a ‘no deal’ exit, it will impose full third country controls on people and goods entering the EU from the UK. The cross-government planning assumption has therefore been revised to prepare for the potential impacts that the imposition of third country controls by member states could have. The revised assumption shows that there will be significantly reduced access across the short straits, for up to six months.

2.2 Supply of medicines and vaccines

• The Government recognises the vital importance of medicines and vaccines, and has developed a UK-wide contingency plan to ensure the flow of these products into the UK in a ‘no deal’ scenario.

• The plan covers medicines used by patients and service users in all four nations of the UK, as well as the UK Crown Dependencies. The Department is working very closely with the devolved administrations, the Crown Dependencies and other government departments to explore specific issues related to the various supply chains for medicines in the UK, as well as potential
mitigations. The plan covers medicines used by all types of providers, including private providers.

• Earlier this year, the Department undertook an analysis using Medicines and Healthcare Products Regulatory Agency and European Medicines Agency data, on the supply chain for all medicines (including vaccines and medical radioisotopes). This identified those products that have a manufacturing touch point in the EU or wider EEA countries.

• In August 2018, the Department for Health and Social Care wrote to pharmaceutical companies that supply the UK with prescription-only and pharmacy medicines from, or via, the EU or European Economic Area (EEA) to prepare for a no deal scenario. Companies were asked to ensure they have a minimum of six weeks' additional supply in the UK, over and above their business as usual operational buffer stocks, by 29 March 2019. Companies were also asked to make arrangements to air freight medicines with a short shelf life, such as medical radioisotopes.

• Since then, there has been very good engagement from industry to ensure the supply of medicines is maintained in a 'no deal' exit.

• The Department will support manufacturers taking part in the contingency planning and is already providing funding for the provision of additional capacity for the storage of medicines.

• In October, the Department invited wholesalers and pre-wholers of pharmaceutical warehouse space to bid for government funding to secure the additional capacity needed for stockpiled medicines, and funding for selected organisations has now been agreed.

• On 7 December 2018, the Department wrote to UK manufacturers of medicines currently using the short straits crossings of Dover and Folkestone as they will want to review supply arrangements in light of the Government’s updated planning assumptions.

• Whilst the six-week medicines stockpiling activity remains a critical part of the Department’s UK-wide contingency plan, it is now being supplemented by additional national actions.

• The Government is working to ensure there is sufficient roll-on, roll-off freight capacity to enable medicines and medical products to continue to move freely into the UK.

• The Government has agreed that medicines and medical products will be prioritised on these alternative routes to ensure the flow of all these products will continue unimpeded after 29 March 2019. This includes all medicines, including general sales list medicines.

• In the event of delays caused by increased checks at EU ports, the Department will continue to develop the UK-wide contingency plan for medicines and vaccines with pharmaceutical companies and other government departments.

• UK health providers – including hospitals, care homes, GPs and community pharmacies – should not stockpile additional medicines beyond their business as usual stock levels. There is also no need for clinicians to write longer NHS prescriptions and the public should be discouraged from stockpiling.

• Chief and Responsible Pharmacists are responsible for ensuring their organisation does not stockpile medicines unnecessarily. Any incidences involving the over-ordering of medicines will be investigated and followed up with the relevant Chief or Responsible Pharmacist directly.
• The Department and NHS England and Improvement are developing arrangements to allow local and regional monitoring of stock levels of medicines; arrangements are also likely to be put in place to monitor the unnecessary export of medicines.

• The Department is putting in place a “Serious Shortage Protocol”. This will involve changes to medicines legislation that will allow flexibility in primary care dispensing of medicines. Robust safeguards will be put in place to ensure this is operationalised safely, including making authoritative clinical advice available.

• Public Health England (PHE) is leading a separate UK-wide programme ensuring the continuity of supply for centrally-procured vaccines and other products that are distributed to the NHS for the UK National Immunisation Programme or used for urgent public health use. In addition to the national stockpiles that PHE has in place to ensure continued supply to the NHS, PHE continues to work alongside contracted suppliers on their contingency plans to ensure that the flow of these products will continue unimpeded in to the UK after exit day.

Supply of medical devices and clinical consumables

• On 23 October 2018, the Secretary of State for Health and Social Care wrote to all suppliers of medical devices and clinical consumables updating them on the contingency measures the Department is taking to ensure the continuity of product supply.

• One of these measures is to increase stock levels of these products at a national level in England.

• The Department is working with the devolved nations and Crown Dependencies to ensure that national contingency arrangements are aligned and able to support specific preparedness measures necessary to meet the needs of their health and care systems.

• The Department is also developing contingency plans to ensure the continued movement of medical devices and clinical consumables that are supplied from the EU directly to organisations delivering NHS services in England.

• The Department has asked all suppliers that regularly source products from EU countries to review their supply chains and determine what measures they need to take to ensure the health and care system has access to the products it needs.

• NHS Supply Chain officials are also contacting suppliers who routinely import products from the EU to establish what measures are required to ensure they can continue to provide products in a ‘no deal’ scenario. Products are already being ordered.

• The Government is working to ensure there is sufficient roll-on/roll-off freight capacity to enable medicines and medical products to continue to move freely into the UK. This will help facilitate the flow of products to both NHS and private care providers.

• The Government has agreed that medicines and medical products will be prioritised on these alternative routes to ensure the flow of these products will continue unimpeded after 29 March 2019.

• There is no need for health and adult social care providers to stockpile additional medical devices and clinical consumables beyond business as usual stock levels. Officials in the Department will continually monitor the situation and, if the situation changes, will provide further guidance by the end of January 2019.
• The Department continues to engage directly with industry suppliers, trade associations, NHS providers and other government departments to develop its contingency planning approach and ensure the continued supply of medical devices and clinical consumables into the UK.

2.3 Supply of non-clinical consumables, goods and services

• The Department has identified categories of national suppliers for non-clinical consumables, goods and services that it is reviewing and managing at a national level. Examples of relevant categories include food and laundry services.
• For these categories, the Department is engaging with suppliers and industry experts to identify and plan for any supply disruption. Where necessary, there will be cross-government work to implement arrangements at the point of EU Exit to ensure continued supply.
• On food, for example, the Department is engaging with both suppliers and health experts to identify and plan for any food items that might suffer supply disruption in the event of a 'no deal'. Standard guidelines will be developed for health and adult social care providers on suitable substitution arrangements for any food items identified as being at risk.
• The Department is also conducting supply chain reviews across the health and social care system to assess commercial risks. This includes reviews for high-risk non-clinical consumables, goods and services, and a self-assessment tool for NHS Trusts and Foundation Trusts. The results of these self-assessments were received at the end of November, and the Department is conducting analysis of the data, that will be used to provide additional guidance to Trusts and Foundation Trusts in January 2019.

2.4 Workforce

• The current expectation is that there will not be a significant degree of health and care staff leaving around exit day. Organisations can escalate concerns through existing reporting mechanisms to ensure there is regional and national oversight.

EU Settlement Scheme

• Through the EU Settlement Scheme, EU citizens will be able to register for settled status in the UK if they have been here for five years, or pre-settled status if they have been here for less than five years. This will ensure the rights of EU citizens are protected in the UK after EU Exit, and guarantee their status and right to work.
• Some EU citizens working in the health and care system would have been able to register for EU settled status under the pilot scheme that was open between the 3rd and 21st December 2018. People that did not register under the pilot scheme do not need to worry as the scheme will be fully open by March 2019 and remain open until 31 December 2020 in a 'no deal' scenario, so there will be plenty of time for EU staff to register.

2.5 Professional regulation (recognition of professional qualifications)

• Health and care professionals (including UK citizens), whose qualification has been recognised and who are registered in the UK before 23:00 on 29 March 2019, will continue to be registered after this point.
• Health and care professionals (including UK citizens), who apply to have their qualification recognised in the UK before 23:00 on 29 March 2019, will have their application concluded under current arrangements.
• Health and care professionals (including UK citizens) with an EU/EEA or Swiss qualification, who apply to have their qualification recognised in the UK from 23:00 on 29 March 2019 will be subject to future arrangements.

2.6 Reciprocal healthcare

• These plans are without prejudice to the rights and privileges available to Irish citizens in the UK, and UK citizens in Ireland, under the Common Travel Area arrangements.

• In a ‘no deal’ scenario, UK nationals resident in the EU, EEA and Switzerland may experience limitations to their access to healthcare services. The Government is therefore seeking to protect current reciprocal healthcare rights through transitional bilateral agreements with other member states.

• The Government has recently introduced the Healthcare (International Arrangements) Bill to ensure we have the legal powers to enter into such agreements in a ‘no deal’ scenario. The Bill could support a broad continuance of the existing reciprocal healthcare rights under current EU regulations (such as the European Health Insurance Card).

• The Government will issue advice via www.gov.uk and www.nhs.uk to UK nationals living in the EU, to UK residents travelling to the EU and to EU nationals living in the UK. It will explain how the UK is working to maintain reciprocal healthcare arrangements, but this will depend on decisions by member states. It will set out what options people might have to access healthcare under local laws in the member state they live in if we do not have bilateral agreements in place, and what people can do to prepare. These pages will be updated as more information becomes available.

• As is currently the case, if UK nationals living in the EU face changes in how they can access healthcare, and if they return permanently to the UK and take up ordinary residence here, they will be entitled to NHS-funded healthcare on the same basis as UK nationals already living here.

• It is not possible to quantify how many people might return due to changes in reciprocal healthcare, and it is important to note that people might return to the UK for many other reasons such as changes in legal status or costs of living.

Research and clinical trials

2.7 EU research and innovation funding schemes

• The Government has guaranteed funding committed to UK organisations for certain EU funded projects in the event of a ‘no deal’ scenario. This includes the payment of awards where UK organisations successfully bid directly to the EU while we remain in the EU, and the payment of awards where UK organisations are able to successfully bid to participate as a third country after EU Exit, until the end of 2020.

• This means that successful bids for EU programme funding until the end of 2020 will receive their full financial allocation for the lifetime of the project.

Clinical networks

• In a ‘no deal’ scenario, UK clinicians would be required to leave European Reference Networks (ERNs) on 29 March 2019. However, the UK will seek to strengthen and build new bilateral and multilateral relationships — including with the EU — to ensure clinical expertise is maintained in the UK.
• The Department and NHS England are in contact with the ERNs and no action is required at this stage. Further information will be communicated to the NHS and professional bodies in due course.

2.8 Clinical trials and clinical investigations

• The Government has issued guidance on the supply of investigational medicinal products (IMPs) for clinical trials in a 'no deal' scenario.
• The Department continues to engage with the life sciences industry regarding contract research and clinical trials of IMPs and medical devices. The Department is working closely with the NHS and is undertaking a comprehensive assessment of the potential impact of 'no deal' exit on clinical trials and investigations, to gain a greater understanding of those which might be affected by supply issues. This includes examining supply chains for IMPs, medical devices, in vitro diagnostic devices, advanced therapy medicinal products, radioisotopes and other clinical consumables, used in clinical trials and investigations, which originate from, or travel through, the EU and EEA. This assessment aims to conclude in January 2019 and, if necessary, further guidance will be issued thereafter.

• All organisations participating in and/or recruiting patients to clinical trials or clinical investigations in the UK should contact their relevant trial sponsors for confirmation of plans for supply chains for IMPs and medical devices as soon as possible.

• The Department has communicated with Sponsors of trials to emphasise their responsibility for ensuring the continuity of IMP supplies for their trials. The Government will monitor for any clinical trials or clinical investigations impacted due to disruptions to clinical trial supplies. Organisations should therefore continue to participate in and/or recruit patients to clinical trials and clinical investigations from 29 March 2019, unless they receive information to the contrary from a trial sponsor, organisation managing the trial or investigation, or from formal communications.

2.9 Clinical Trial Regulation

• For EU-wide trials, the new EU Clinical Trial Regulation (CTR) will not be in force in the EU on 29 March 2019 and so will not be incorporated into UK law.

• However, the Government has stated the UK will align where possible with the CTR without delay when it does come into force in the EU, subject to usual parliamentary approvals. This will provide certainty for organisations conducting trials in the UK.
• Those organisations carrying out clinical trials should follow the normal process for seeking regulatory approval.

2.10 Data sharing, processing and access

• It is imperative that personal data continues to flow between the UK, EU and EEA member states, following our departure from the EU. The Department for Digital, Culture, Media and Sport and the Information Commissioner’s Office (ICO) have released guidance on data protection in a 'no deal' scenario, which can be viewed on gov.uk and the ICO website.

• The European Commission is unlikely to have made a data protection adequacy decision regarding the UK before EU Exit. An adequacy decision is where the European Commission is satisfied that a transfer of personal data from the EU/EEA to a country outside the EU/EEA would be adequately protected.
• Transfers of personal data from the UK to the EU/EEA should not be affected in a 'no deal' scenario. This is because it would continue to be lawful under domestic legislation for health and adult social care organisations to transfer personal data to the EU/EEA and adequate third countries in the same way we do currently.

• At the point of exit, EU/EEA organisations will consider the UK a third country. This will mean the transfer of personal data from the EU/EEA to the UK will be restricted unless appropriate safeguards are put in place.
• In order to ensure that personal data can continue to be transferred from organisations in the EU/EEA to the UK in the event there is no adequacy decision, alternative mechanisms for transfer may need to be put in place. This is the case even if organisations are currently compliant with the GDPR.

• One solution you could consider, which the ICO states that most businesses find to be a convenient safeguard, particularly when dealing with non-public organisations, is to use one of the standard contractual clauses (SCCs) approved by the EU Commission. Guidance on these SCCs can be found in the links to gov.uk and the ICO website.

3 COMMAND AND CONTROL

3.1 Activation

In the event of a no deal EU Exit this plan will be activated and the EU Exit Group will meet to discuss initial actions required. Depending on the scale and impact of the EU Exit, the group will decide on the next required meeting.

3.2 Management of the Response

3.2.1 Management during the initial phases

During the initial phases of a EU Exit, the EU Exit Group will lead the actions required. The Chief Operating Officer, will decide whether any sub groups need to be activated at this stage.

3.2.2 Management during a no deal EU Exit with minimal to low impact.

The Trust response to a no deal EU EXit will be managed with the formation of a EU Exit Group, which will be a subsidiary of and report to the Emergency Preparedness Group. The core members of this group will be:

• Emergency Planning Leads
• Service Directors
• Pharmacy
• Information Governance
• Communications
• Procurement
• Human Resources

Additional members will be requested to attend as and when required.
3.2.3 Management during medium to high impact

Where a medium to high impact is occurring, and is having a significant impact on services, it may be necessary for the Chief Operating Officer to declare an Internal Incident and form an Incident Management Team (Silver) and Gold Command to manage the response to the incident.

The Incident Management Team will be led by the Director On call as gold, and should include representation from those who attended the EU Exit Group and additional members where required.

The actions outlined in the EU Exit Guidance and Slam EU Exit risk register should be used by this working group as an aide-memoir for operational actions to be undertaken. As such the key agenda items for these meetings should include:

- **Staffing levels.** The group should have up to date staffing levels across the Trust to allow them to implement a staffing plan to ensure sufficient and safe staffing across all areas.
- **Essential Supplies.** The Group should have up to date stock levels for essential supplies to ensure that the Trust has suitable supplies for the coming days.
- The frequency (and membership) of the EU Exit Group / Incident Management Team will be set by the Chief Operating Officer (for EU Exit Group) or On Call Director – Gold (Incident Management Team).

3.3 Concurrent Incidents

In the event of a critical or business continuity incident taking place during a no deal EU Exit, all escalation arrangements will be utilised as detailed within the Incident response plan.

4 RESPONSE BY SOUTH LONDON AND MAUDSLEY NHS TRUST

Slam’s response to a no deal EU Exit are intended to be proportionate to the nature and scale of any staffing issues, delays to the supply chain, breaches of information governance legislation and the wider pressures on healthcare services.

The Trusts anticipated response to impact events is provided below. However, it should be noted that in responding to any incident the responses actions are not exhaustive, as such it may be necessary to implement additional responses.

4.1 Confirmed no deal EU Exit

<table>
<thead>
<tr>
<th>ACTIONS</th>
<th>Healthcare Delivery Impacts</th>
</tr>
</thead>
<tbody>
<tr>
<td>Nature and Scale of issues</td>
<td>Limited impacts - business continuing as usual maintained as far as possible</td>
</tr>
<tr>
<td>Reports of sporadic reduction in staffing levels AND/OR</td>
<td>Possible increase in number of EU Related</td>
</tr>
<tr>
<td>Limited number of delays in supplies from the EU AND/OR</td>
<td></td>
</tr>
</tbody>
</table>

Page 16 of 27
- Increased ratio of EU Exit Related Incidents

### South London and Maudsley NHS Trust Specific Actions
Managed by Emergency Preparedness Group or EU Exit Group if requested by the Chief Operating Officer

<table>
<thead>
<tr>
<th>Actions</th>
<th>Owner/Responder</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Initiate urgent review of current EU Exit plans, business continuity and surge/escalation arrangements in line with updated guidance if required and any emerging information, reporting findings to the Emergency Preparedness Group.</td>
</tr>
<tr>
<td>2</td>
<td>Assess availability of medicines and essential resources.</td>
</tr>
<tr>
<td>3</td>
<td>Attend Borough Resilience Forum if requested.</td>
</tr>
<tr>
<td>4</td>
<td>Review current response strategies in respect of any updated practices and past experience.</td>
</tr>
<tr>
<td>5</td>
<td>Ensure trust-wide EU Exit arrangements are fit for purpose and carry out testing as required</td>
</tr>
<tr>
<td>6</td>
<td>Ensure subcontractors and commissioned services have adequate response plans in place.</td>
</tr>
<tr>
<td>7</td>
<td>Increase awareness of the issues which are being highlighted by a no deal EU Exit. Newsletter, Intranet etc</td>
</tr>
<tr>
<td>8</td>
<td>Review the use of procurement and supply chain procedures.</td>
</tr>
<tr>
<td>9</td>
<td>Implement record keeping and surveillance measures for any EU Exit related incidents</td>
</tr>
<tr>
<td>10</td>
<td>COO establishes EU Exit Group is deemed necessary</td>
</tr>
<tr>
<td>11</td>
<td>Continue Business as normal</td>
</tr>
</tbody>
</table>

### Ongoing monitoring of the nature and scale of an EU Exit nationally and its effect on healthcare delivery

#### 4.2 Assess

### ASSESSMENT PHASE ACTIONS

<table>
<thead>
<tr>
<th>Nature and Scale of Incidents</th>
<th>Healthcare Delivery Impacts</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Increased numbers in delays to supplies AND • Indicative number of reports of staff reduction/disruption</td>
<td>NHS England coping with supplies centrally WITH No significant deferral of usual activities AND/OR Potential for increased staff absence due to disruption</td>
</tr>
</tbody>
</table>

### South London and Maudsley NHS Trust Specific Actions
Managed by the EU Exit Group

<table>
<thead>
<tr>
<th>Actions</th>
<th>Owner/Responder</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Ensure Trust attendance at all relevant groups</td>
</tr>
</tbody>
</table>
and committees (with representation from the appropriate services).

<table>
<thead>
<tr>
<th>2</th>
<th>Set up reports including number of service users and staff affected, and enhance surveillance and/or data collection to reflect NHS England data requests.</th>
<th>EU Exit Group</th>
</tr>
</thead>
<tbody>
<tr>
<td>3</td>
<td>Review staffing levels and implement Business Continuity measures if required communicating any changes to services to staff and service users.</td>
<td>Service Managers EU Exit Group</td>
</tr>
<tr>
<td>4</td>
<td>Assess availability of medicines and essential resources.</td>
<td>Pharmacy Lead</td>
</tr>
<tr>
<td>5</td>
<td>Consider the implementation of additional resources for service users impacted by the disruption.</td>
<td>EU Exit Group</td>
</tr>
<tr>
<td>6</td>
<td>Establish supply chain/procurement procedures. Working with procurement/pharmacy to purchase additional stocks as required.</td>
<td>Procurement/Pharmacy</td>
</tr>
<tr>
<td>7</td>
<td>Liaise with NHS (England) regarding planning for additional service requirements.</td>
<td>Emergency Planning Leads</td>
</tr>
<tr>
<td>8</td>
<td>Attend Borough Resilience Forum if requested.</td>
<td>Emergency Planning Leads</td>
</tr>
<tr>
<td>9</td>
<td>Ensure subcontractor and commissioned services are putting their response plans in place (if required).</td>
<td>EU Exit Group Estate &amp; Facilities Procurement</td>
</tr>
<tr>
<td>10</td>
<td>Review staff skills including volunteers and recently retired staff lists and their training requirements if required to support services under pressure.</td>
<td>HR Departmental Managers Volunteer Manager</td>
</tr>
<tr>
<td>11</td>
<td>Provide communications messages as required and monitor social media</td>
<td>Communications Team</td>
</tr>
<tr>
<td>12</td>
<td>Continue business as usual as far as possible</td>
<td>All Staff</td>
</tr>
</tbody>
</table>

Ongoing monitoring of the nature and scale of incidents nationally and its effect on healthcare delivery

4.3 **Interventions**

### INTERVENTION PHASE ACTIONS

<table>
<thead>
<tr>
<th>Nature and Scale of Incidents</th>
<th>Healthcare Delivery Impacts</th>
</tr>
</thead>
</table>
| • Increased number of EU Exit related incidents, staff reduction/disruptions.  
  *WITH*  
  • Severe delays in supplies  
  *AND/OR*  
  • Increased referrals, services at capacity | Health services no longer able to continue all activity  
  *WITH*  
  Local and regional decisions to cease some healthcare activity  
  *AND/OR*  
  Pharmacy under severe pressure  
  Supplies under severe pressure  
  Increased referrals, services over capacity |

**South London and Maudsley NHS Trust Specific Actions**

Managed by the EU Exit Group or the Incident Management Team if requested by the Chief Operating Officer

<table>
<thead>
<tr>
<th>Actions</th>
<th>Owner/Responder</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Task</td>
</tr>
<tr>
<td>---</td>
<td>---------------------------------------------------------------------</td>
</tr>
<tr>
<td>2</td>
<td>Establish extra resources</td>
</tr>
<tr>
<td>3</td>
<td>Support staff and service users in visa application.</td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td>4</td>
<td>Review reports of service users affected and implementing work force</td>
</tr>
<tr>
<td></td>
<td>measures as needed.</td>
</tr>
<tr>
<td>5</td>
<td>Assess availability of medicines and essential resources.</td>
</tr>
<tr>
<td>6</td>
<td>Monitor the provision of services and implement business continuity</td>
</tr>
<tr>
<td></td>
<td>measures if trigger points are reached (communicating any changes</td>
</tr>
<tr>
<td></td>
<td>to service delivery to service users and staff). Arrange for the</td>
</tr>
<tr>
<td></td>
<td>reallocation of staff from non-essential services if required.</td>
</tr>
<tr>
<td>7</td>
<td>Review current procurement procedures and supply chains. Advise</td>
</tr>
<tr>
<td></td>
<td>changes to procurement criteria if necessary (considering the</td>
</tr>
<tr>
<td></td>
<td>impact on vulnerable service users).</td>
</tr>
<tr>
<td>8</td>
<td>Review use of current suppliers. Explore options of sourcing</td>
</tr>
<tr>
<td></td>
<td>alternative suppliers or trade routes.</td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td>9</td>
<td>Review guidance on EU Exit strategies/plans.</td>
</tr>
<tr>
<td>10</td>
<td>Review Trust plans and arrangements considering current</td>
</tr>
<tr>
<td></td>
<td>information and public reaction.</td>
</tr>
<tr>
<td>11</td>
<td>Attend Borough Resilience Forum and other associated forums.</td>
</tr>
</tbody>
</table>

**Ongoing monitoring of the nature and scale of incidents nationally and its effect on healthcare delivery**

### 4.4 Escalate

#### ESCALATION PHASE ACTIONS

<table>
<thead>
<tr>
<th>Nature and Scale of Illness</th>
<th>Healthcare Delivery Impacts</th>
</tr>
</thead>
<tbody>
<tr>
<td>Widespread impact in the UK</td>
<td>GPs, pharmacies, acute trusts, mental health trusts, district nurses and social carers,</td>
</tr>
<tr>
<td>WITH</td>
<td>independent sector, residential homes and voluntary organisations fully-stretched trying</td>
</tr>
<tr>
<td>Most suppliers affected</td>
<td>to support essential care in the community</td>
</tr>
<tr>
<td>AND/OR</td>
<td>Consequential pressure on secondary care</td>
</tr>
<tr>
<td>Severe impact on service</td>
<td>Hospitals can only provide essential services</td>
</tr>
<tr>
<td>delivery and vulnerable</td>
<td>Impacts on transport and schools may affect staffing</td>
</tr>
<tr>
<td>persons.</td>
<td></td>
</tr>
</tbody>
</table>
### South London and Maudsley NHS Trust Specific Actions

**Managed by Incident Management Team**

<table>
<thead>
<tr>
<th>Actions</th>
<th>Owner/Responder</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Continue with actions required during medium to high impact event</td>
</tr>
<tr>
<td>2</td>
<td>Regularly report situation to EU Exit Group.</td>
</tr>
<tr>
<td>3</td>
<td>Establish daily briefing bulletin.</td>
</tr>
<tr>
<td>4</td>
<td>Review data collection and surveillance requirements during peak period.</td>
</tr>
<tr>
<td>5</td>
<td>Review staff absence rates and ability to resource essential services.</td>
</tr>
<tr>
<td>6</td>
<td>Implement essential work only plans for community based services.</td>
</tr>
<tr>
<td>7</td>
<td>Review implications of change in duties for redeployed staff and establish staff pool if required.</td>
</tr>
<tr>
<td>8</td>
<td>Review supply chain and procurement process.</td>
</tr>
<tr>
<td>9</td>
<td>Communicate latest EU Exit to staff and service users</td>
</tr>
<tr>
<td>10</td>
<td>Seek alternative suppliers</td>
</tr>
<tr>
<td>11</td>
<td>Confirm with current suppliers the level of response and estimated delays</td>
</tr>
<tr>
<td>12</td>
<td>Ensure regular communication updates are issued.</td>
</tr>
<tr>
<td>13</td>
<td>Implement any reduced service policies agreed with contractors.</td>
</tr>
<tr>
<td>14</td>
<td>Assess availability of medicines and essential resources.</td>
</tr>
<tr>
<td>15</td>
<td>Ensure deputies are appointed to all key roles in case of illness / absence.</td>
</tr>
<tr>
<td>16</td>
<td>Attend Borough Resilience Forum, and other associated forums.</td>
</tr>
<tr>
<td>17</td>
<td>Establish Recovery Management Team</td>
</tr>
</tbody>
</table>

Ongoing monitoring of the nature and scale of incidents nationally and its effect on healthcare delivery

### 4.5 Recovery

**RECOVERY PHASE ACTIONS**

Once the number of cases incidents has been confirmed as reducing on a weekly basis, it will be important to manage the reimplementation of services based on the availability of staff and resources and the impact the EU Exit has had on the local population. Recovery measures, including the provision of psychological counselling for both staff and the public will also be required.

**South London and Maudsley NHS Trust Specific Actions**

**Managed by Recovery Management Team**

<table>
<thead>
<tr>
<th>Actions</th>
<th>Owner/Responder</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Agree stand down of Incident Management Team / EU Exit Group</td>
</tr>
<tr>
<td>2</td>
<td>Assess pressures and redeploy staff and resources where necessary to relieve short term pressures.</td>
</tr>
<tr>
<td>3</td>
<td>Review availability of services and implement recovery strategy.</td>
</tr>
</tbody>
</table>
4. Review availability of contracted services and suppliers.
   Recovery Management Team
   Estates & Facilities

5. Review absence levels and allocate additional or authorised leave where appropriate.
   Human Resources
   Departmental Managers

6. Review admission protocols for and reintroduction of services.
   Recovery Management Team

7. Remove additional resources and support
   Recovery Management Team

9. Ensure regular communication updates are issued regarding changes to services and EU arrangements.
   Communications

10. Review surveillance and data collection methods.
    Recovery Management Team

13. Reduce the frequency of bulletins as appropriate.
    Communications

14. Reduce rotas and duties (where necessary) for seconded / volunteer staff.
    Service Managers

15. Review effectiveness of local communication methods and information.
    Communications

17. Carry out post-incident debrief
    Chief Operating Officer

18. Prepare Financial Impact Analysis
    Emergency Planning Leads

19. Prepare a debrief report for submission to the Senior Management Team and Trust Board
    Emergency Planning Leads

On-going monitoring on the ongoing effects of the EU Exit on healthcare delivery

5 ESCALATION ARRANGEMENTS

The no deal EU Exit escalation arrangements to be considered by the EU Exit Group/Incident Management Team will be used to provide a progressive and proportionate response to a no deal EU Exit scenario.

5.1 Supplies and Equipment

The normal level of stock holding will be maintained for the duration of the affected period, as such it is anticipated that no additional stockpiling of supplies and equipment will be undertaken. Local supplies of stocks should be maintained on a regular basis, with orders/requests for replenishment made in advance of stocks becoming diminished. Careful consideration should be given to stock holdings over the holiday period, where deliveries are likely to be less frequent.
6 WORKFORCE PLANNING

6.1 Maximising Available Staff

During a low and medium impact, departmental Business Continuity Plans should be sufficient to continue providing business as usual. However, during a protracted or high impact the Trust will need to maximise the use of available staff through re-deployment, with the suspension of non-critical activities within the Trust as determined by the EU Exit Group/Incident Management Team.

The Trust has defined a set of seven generic roles to which staff may be pre-assigned from non-essential services to allow training needs to be supported.

- Knowledge and skills to provide inpatient care in line with the provisions of mental health law.
- Knowledge and skills to provide community based care in line with the provisions of mental health law.
- Critical care skills able to care for young persons admitted to the hospital.
- Critical care skills able to care for young persons based in the community.
- Fundamental care skills to include washing, dressing, and assistance with nutrition and hydration
- Administrative skills to include answering phones, reception duties, filing and basic PC skills
- General duties to include cleaning, portering, stocking with basic training on patient care provided.

If staff need to be redeployed or work needs to be reallocated the following principles will apply:

- Staff will not be expected to undertake roles outside the level of their competence.
- Staff will have the skills and knowledge to work safely
- All reasonable measures will be put in place to ensure the health and safety of staff.
- Staff will be paid on their existing grades.

Where required, training and immunisation will be provided to allow staff to undertake the role.

- Retirees: The Human Resources Department will write to former staff who have retired from clinical roles within the previous 12 months to invite them to assist the Trust in its response.
- Volunteers: If required, the EU Exit Group will request the Volunteer Manager helps to identify volunteers that can assist in the response. All volunteers are DBS checked.

Staffing reallocation will be coordinated by the EU Exit group/Incident Management Team, who may establish a staff pool run by HR if required. Any staff member or volunteer deployed to assist, in the response to another area of the hospital that they would not normally work in, will be given an induction and appropriate level of support.

6.2 Failure to Attend Work
The Trust expects that unless staff are unwell themselves, it will be exceptional for the member of staff to not be able to attend work in some capacity. Staff who do not attend work because they are unwell should report to their manager in the normal way.

Staff with caring responsibilities should be dealt with on a sympathetic basis, however the Trust and the individual should work together to agree attendance at work in some capacity during a high impact event. Limited child care arrangements are available within the Trust, and may be reviewed in response to a Moderate and high impact events.

6.3 Working Time Directive

The European Working Time Directive specifies clear rest requirements and limits to working hours for all staff. HR will be required to attend the EU Exit Group / Incident Management Team to provide advice.

Where possible the Trust will support all staff to comply with the rest requirements of the Working Time Directive; monitoring the situation and making the necessary adjustments to ensure compliance with limits to working hours during any episodes of staff shortage. Given the reduction in staffing numbers could extend over a period of 4-6 weeks, the Trust expects staff to be able to achieve an average working week of less than 48 hours over the 17-week reference period in place.

In accordance with the law, staff can opt out of the limits to the working time directive (average 48 hours per week), this option will continue to be available to staff; however, it should be noted that working time regulations are Health and Safety legislation and it is essential that staff achieve appropriate rest to support safe delivery of care.

7 REPORTING AND RECORD KEEPING

7.1 Reports

For the Trust to maintain an overview of the impact and therefore respond to the incident it will be necessary to undertake regular reporting. The frequency and information required will be set by the EU Exit Group / Incident Management Team, however it is recommended that Internal reports are submitted by 10.00am to allow daily Incident Management Team Meetings to be held if required.

Reports will be required by NHS England (London) and will provide assurance to NHS England of the Trust’s ability to continue delivering services. Clinical Commissioning Groups may also need to have sight of this, along with other partners.

7.2 Record Keeping

During the disruption Incident logs of all decisions and actions taken by the EU Exit Group or Incident Management Team and any messages received in relation to the incident will be documented and recorded. Completed paperwork should be returned to the Emergency Planning Leads for storage.

All meetings relating to a no deal EU Exit should be documented with agreed minutes, which should be returned to the Emergency Planning Leads for storage following the incident.

8 COMMUNICATIONS
Communications both internal and external (including to the media) will be undertaken by the Communications Team, who will be responsible for handling all press and media enquiries. The Communications team will be represented on the EU Exit Group and Incident Management Team.

8.1 Internal Communications

In the event of a no deal EU Exit scenario it will be necessary for staff to be made aware of the developing situation. It is intended that general messages and briefings to staff will be set by The EU Exit Group, however a general statement can be circulated to all staff once this plan is activated.

The Trust recognises that there may be high levels of anxiety an EU Exit and working in new or adjusted roles. The Trust will ensure communications let staff have a realistic assessment of the related changes/risks and how they can be minimised and provide relevant information.

Internal Communications will include use of hospital wide email, intranet and staff team briefings. The Communications team will prepare reactive statements for:

- Activation of this Plan.
- Changes to working procedures
- Recovery and return to normal.

8.2 External Communications

In the event of a no deal EU Exit scenario it will be necessary for stakeholders and the press and media to be reassured of the Trusts operational ability to continue delivering essential services. The Communications Department will handle all media enquiries and will prepare reactive statements for:

- Communications to Stakeholders
- Routine enquiries relating to the EU Exit and its impact to the Trust.
- The Trusts ability to continue delivering critical services.
- Recovery and return to normal.

Staff in reception, PALS, crisis line and complaints will be given specific information to help them advise any patients, visitors or members of the public who telephone or turn up in person for help or advice.

9 STAND DOWN

9.1 Stand down

This plan will be stood down by the highest tier of command in operation when the incident can be managed under normal arrangements and impact of the EU Exit on hospital operations has been significantly reduced.

9.2 Debrief

Debriefs are important opportunities to learn from incidents and review/develop the EU Exit plan. Debriefing following the incident is as per the Incident Response Plan. At the
earliest opportunity following stand down a hot debrief should be carried out within all areas involved in the response, this should be short, structured and recorded. All debrief notes, along with log books/sheets should be sent to the Emergency Planning Leads for collation into the serious incident investigation/report and safekeeping.

A wider whole hospital debrief will be held within one month of the incident, using information from the hot debrief and departmental debrief meetings.

The wider whole hospital debrief will be co-ordinated by the incident Gold Commander, Chief Operating Officer and the Emergency Planning Leads and conducted by a director not involved in the response. Where required, external agencies will also be invited to attend.

A report following the debriefing meeting will be produced by the Emergency Planning Leads, which will identify actions to improve plans and procedures and will be presented to the Emergency Preparedness Group. It is likely that in the event of a no deal EU exit scenario, multi-agency debriefs will also be held, which should be attended by the Emergency Planning Leads and other key staff involved in the response.

10 ROLES AND RESPONSIBILITIES

<table>
<thead>
<tr>
<th>All Managers/Department Heads</th>
<th>Planning phase</th>
<th>Maintain service/departmental Business Continuity Plans as appropriate / required.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Response phase</td>
<td></td>
<td>• Brief staff as required/appropriate of emerging risks and any changes in interventions / escalation phases</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Monitor Staff absence and departmental capacity completing reports as required.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Report any delays/impact on supplies.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Support Site Management and/or EU Exit Group as required.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Report any issues with staffing, resources etc to the EU Exit Group / Incident Management Team</td>
</tr>
</tbody>
</table>

| Human Resources | Response phase | Establish and manage the strategy for HR with regard to staff redeployment, wellbeing and absence, against the EU Exit workforce management plan in conjunction with the EU Exit Group / Incident Management Team. |

| Emergency Planning Leads | Planning Phase | • Ensure maintenance of this plan, arranging for training and exercising to be carried out. |
|                          |                | • Monitor relevant sources of information during potential and no deal EU exit scenario and communicate to relevant staff members. |
|                          |                | • Maintain communication and relationships with partners such as NHS England (London), ensuring Trust attendance at external meetings/briefings as required. |
|                          | Response Phase | • Participate in internal meetings and teleconferences held in response to the no deal EU Exit, acting as a Tactical advisor to the EU Exit Group / Incident Management Team as required. |
|                          |                | • Arrange for the storage of all records and documentation in relation to the |
## Communications

### Response phase
- Establish the Communications strategy to staff, stakeholders and the media in conjunction with the Silver/Gold in command of the incident.
- Promote increased awareness of changes and risk measures in conjunction with the EU Exit Group.
- Establish daily bulletins during high impact to keep staff up to date.
- Ensure communications to staff and the public regarding changes to services.
- Monitor and inform Silver/Gold of negative media relating to the wider NHS, and the Trust.
- Undertake all media handling on behalf of the Trust.

### Chief Pharmacist

#### Response phase
- Attend the EU Exit Group / Incident Management Team when requested.
- Review stocks and availability of other essential medications.

### Chief Operating Officer

#### Response phase
- Establish and chair the EU Exit Group.
- Agreed movement through the intervention and escalation phases.

### EU Exit Group / Incident Management Team

#### Response phase
- Coordinate the response to the incident on behalf of the Trust, implementing existing escalation plans as required.
- Report to the On-Call Director / Gold as required.
- Complete Reports as required.
- Implement surveillance and monitoring measures as required.
- Receive and act on advice from NHS England when the trigger for plans is reached.
- Determine the Tactical response for the Trust, liaising with, Clinical Commissioning Groups (CCG) and partners as required.
- Work in conjunction with the Communications Team to approve and release internal and external statements as appropriate.
- Determine the frequency and information set required for reports.
- Maintain hospital services.
- Report the local situation to the Gold Strategic Group as required.
- Stand down response when appropriate.

### On Call Director (Gold)

#### Response phase
- Establish Gold Command in response to a Moderate or High Impact Event, where management of the incident has moved from the EU Exit Group to the Incident Management Team, taking overall responsibility for the incident on behalf of the Trust.
- Establish and chair the Incident Management Team.
- Determine the Strategic response for the Trust, supporting the Incident Management Team as required.
- Receive and act on advice from NHS England.
- Authorise the suspension of non-critical activities with the re-deployment of staff to critical activities.
- Determine the frequency and information set required for reports.
- Provide reports on activity to the Trust Board and Chief Executive as required.
- Work in conjunction with the Communications Team to approve and release internal and external statements.
- Authorise the purchase of additional stocks as required.
- Appoint a Gold Recovery Director handing over command as appropriate.

<table>
<thead>
<tr>
<th>On Call Manager (Silver)</th>
<th>Response phase</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Notify Gold of the need to activate the EU Exit plan Command and Control arrangements</td>
</tr>
<tr>
<td></td>
<td>Receive and act on advice from NHS England when the trigger for EU Exit resilience plans is reached.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Recovery Director</th>
<th>Response phase</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Establish and chair the Recovery Management Team, taking overall responsibility for the Trusts return to business and usual.</td>
</tr>
<tr>
<td></td>
<td>Determine the Strategic response for the return to business as usual.</td>
</tr>
<tr>
<td></td>
<td>Liaise with Gold Command, agreeing handover of incident command when appropriate.</td>
</tr>
<tr>
<td></td>
<td>Provide reports on the return to business as normal to the Trust Board and Chief Executive as required.</td>
</tr>
</tbody>
</table>
Title: Community Services Redesign Plans and Progress

Author: SLaM Borough Service Directors

Accountable Director: Kristin Dominy, Chief Operating Officer

Purpose of the paper
To provide an update to Board on the approach to community services redesign programmes that are underway in the Trust.

Executive Summary:
- Community service redesign programmes, coproduced with partners in our Alliances and Partnerships, are underway in each of our 4 Boroughs. These redesign programmes are all focussed on population based health outcomes and providing the best care and support possible in a community setting.
- All four Borough leads are actively engaged with partners to redesign community services, ranging from an active Alliance in Lambeth to early discussions in Croydon. A great deal of progress is expected in 2019/20 by the end of which it is anticipated that all Boroughs except Croydon will be in some form of Alliance. During the redesign SLaM will set “red lines” to ensure we meet regulatory, financial and clinical quality and practice standards.
- The ICare Community Care Process Model will be the basis of the design; co-produced with service users and employing NICE and Royal College best practice guidance and will have appropriate resource to deliver it.

Risks / issues for escalation
- BAF Risk 1 - Workforce
- BAF Risk 2 – operational delivery structure.
- BAF Risk 3 – Informatics
- BAF Risk 5 - Partnership working with service users.
- BAF Risk 7 - Quality & statutory compliance.
- BAF Risk 8 - Finance - contracts.
- BAF Risk 9 – Estates
- BAF Risk 11 - QI delivery.
- BAF Risk 12 Finance – cost management
- BAF Risk 13 – Mandatory training
- BAF Risk 14 – Patient flow
Community Redesign

Introduction

This is a summary of the approach to the SLaM community services redesign programmes that are underway in the Trust. A more in-depth discussion is at Appendix 1 and detailed Borough plans will emerge as the arrangements for each Borough Alliance are agreed.

Background

While adult acute inpatient services attract much focus it needs to be recognised that around 80% of our inpatients are already known to us prior to admission and the majority of our service users are cared for in community teams. In addition, many roles in the community have become unsustainable such as the care coordinator and we need closer integration between pathways now that we are in Boroughs. These difficulties are in part a consequence of the low levels of investment in community services within the boroughs that SLaM serves. For these reasons, work has been underway for some time to review the community services we offer, align them with Borough plans and introduce standards of care and best practice procedures that are common across the Trust.

Overview and Design Principles

SLaM serves four inner city boroughs characterised by high levels of diversity and deprivation. Each of these boroughs has a unique character, both in terms of demographic but also in terms of local assets and services. SLaM is currently working closely with key stakeholders in each of these boroughs to redesign how mental health services are delivered in the community, aiming to make best use of all local resources. At the same time it is important that consistency is achieved across all of our services around key standards of care.

Our intent is that each Borough should redesign their community services in co-production with local Alliance partners to meet the needs of their local population. It should be noted that all four Boroughs are already working with partners to redesign community services, ranging from an active Alliance in Lambeth to early discussions in Croydon, and a great deal of progress is expected in 2019/20 by the end of which it is anticipated that all Boroughs except Croydon will be in some form of Alliance. During the redesign SLaM will set “red lines” to ensure we meet regulatory, financial and clinical quality and practice standards.

To limit variability between community designs, the following design principles will be followed:

- The ICare Community Care Process Model will be the basis of the design; co-produced with service users and employing NICE and Royal College best practice guidance.
- The design process will look at best use of existing resources, but also look at how redesigned services can then be scaled to deliver sufficient capacity with increased investment.
- All designs should have closer links with primary care, using evidence-based practice. To aid this development SLaM will work with partners on finding IT solutions that limit the need for staff working across integrated systems to double entry on patient data bases.
- Active care plans will be shared across agencies including crisis plans to reinforce self-management behaviours and build confidence of service users to manage crises.
- All designs will have a solution to manage and routinely review community caseloads.
- All designs will have a generic CMHT at the centre providing continuity of care for the service user.
- Wherever possible there will be multi-agency, multi-professional working to break down barriers between teams and settings of care.
- Positive risk taking will be encouraged through multi-agency risk forums.
- All Community Services will define a set of performance and clinical outcome measures that will be agreed by the SLaM Quality Centre and Operations SMT to ensure the design is meeting the needs of the population and standards set by the red lines.
- All boroughs will be working to the principles as outlined in the Ten Year Plan.
- Boroughs will redesign their services iteratively on a road map defined by the relevant Alliance but working towards these principles.
• Each Borough will produce a full staff engagement and consultation plan in line with the Lambeth Alliance engagement approach to ensure staff are fully involved in the process

Current Resourcing Position by Weighted Population

To deliver the ambitious community service plans in each borough the Trust will need to ensure that the Trust is (1) receiving a funding allocation to achieve financial balance in line with NHS regulatory requirements; and (2) drawing in increased investment to align income and capacity with the London average as a minimum, and ideally with its London comparator Trust (NELFT).

2019-20 negotiations are focused on drawing in additional investment to develop community services and align locally commissioned capacity with demand. This will also help to deliver the Trust target of 32 days average length of stay and 85% occupancy as enhanced community services are able to support individuals with complex mental health needs in a community setting. Negotiations are ongoing around investment standards with NELFT as the comparator in an attempt to achieve uplifts in funding from all commissioners. Further details of the weighted population analysis are at Appendix 1.

Work is underway to review how teams in Alliance Structures will develop at scale to meet demand so that additional resources are deployed effectively to deliver the Trust agreed standards and model for community care (recognising there may be local drivers shaping the multidisciplinary nature of teams, including ‘hubs’ and CMHTs based on primary and social care models). Two gaps exist when compared with NELFT, an overall 25% funding gap and a 60-70% capacity gap, in other words SLaM receives less money but also has less community capacity than NELFT, but currently we are not clear whether this is as a result of demographic difference, levels of service provision or service configuration. The funding gap to the London average is slightly less than NELFT at 17%, therefore we intend to seek an uplift in overall funding of 17% and also redesign our community delivery model to do better with the funding we have.

iCare Model for Community Care in SLaM Boroughs

We want to ensure that the people who access our services experience the same standards of care no matter which borough they live in or which service they are under. Both the inpatient and community operational care process models (CPM) are being developed with service users, carers and staff so that people know the fundamental standards of care, namely standards of best practice, they can expect to receive in every ward and community team.

The iCare community CPM introduces operational and clinical standards across all community services. The operational model ensures patients are seen at the right time and in the least restrictive place and the clinical standards ensure that all clinical activity is based on NICE and clinically recognised best practice. Fundamental standards of care are co-produced with service users and clinical experts to ensure we meet clinical best practice, regulatory standards and service user expectations. The CPM will form the basis of all Borough community services as part of their design principles. More details can be found at Appendix 1.

Borough Position Statements

Lambeth

In July 2018 the Lambeth Living Well Network Alliance came into being, which means that the Trust's working age services in Lambeth became formal partners with Certitude, Lambeth Clinical Commissioning Group, Lambeth Council, and Thames Reach. This partnership is committed to meeting the three big outcomes that were co-produced by Lambeth residents, for people living in Lambeth to: recover and stay well; be offered choice, and; participate on an equal foot in their daily lives.

Lambeth have now entered a consultation with all community staff to migrate to the new structure on 13th April 2019
Southwark

SLaM will be a key member of Partnership Southwark from the 1<sup>st</sup> April 2019. Partnership Southwark is a Local Care Partnership that brings together Partners in Southwark to deliver integrated care at a borough and neighbourhood level as part of the overall ‘System of Systems’ approach for South East London. Partnership Southwark will oversee work intended to develop integrated, high quality, affordable and sustainable health and social care services, which are delivered in the most appropriate way.

Partnership Southwark has the following 2019-20 strategic priorities:

- Support and further development of the Neighbourhood mode
- Care Coordination for people with 3 or more LTC
- Improved primary care mental health
- Focused support for care homes and nursing homes
- Prevention & self-management linking to ‘Vital 5’
- Data sharing & Informatics.

Lewisham

Design programmes with SLAM staff were launched late 2018. The initial programme aims to deliver proposals on three workstreams in March with a view to start transforming services from April 2019. The three workstreams are:

- Primary Care Mental Health Team (PCMHT) development: exploring and developing MDT based PCMHTs to manage demand and work jointly with primary care.
- Developing condition specific care pathways informed by NICE guidelines and the ICare CPM and adapted to a neighbourhood PCMHT based service model
- Continuing Care work stream extending Promoting Recovery Team provision and integrating them as start of the step down to primary care via PCMHTs

Croydon

The design work in Croydon is two-fold: We are fully collaborating with the CCG to inform and shape the business case for mental health service provision in Croydon; we are also in the early stages of redesigning our services so that our secondary care offer is more responsive and effective. Over the next 12 months we will:

- Develop an enhanced primary care offer to support people access the right help at the right time in the right setting.
- Review our structures to determine areas for improvement and redesign to be able to deliver condition specific care pathways informed by NICE guidelines.
- Work with primary care and the voluntary sector to improve transition from secondary mental health services
Appendix 1 to Community Services Redesign Plans and Progress Board Paper

SLaM Community Redesign

Overview and Design Principles

Each Borough will redesign their community services in co-production with Alliance partnerships to meet the needs of their local population. During the redesign SLaM will set “red lines” to ensure we meet regulatory, financial and clinical quality and practice standards. However, to limit variability between community designs the following design principles will be followed by SLaM during the co-production:

- The iCare Community Care Process Model will be the basis of the design; co-produced with service users and employing NICE and Royal College best practice guidance and will have appropriate resource to deliver it.
- All designs should have closer links with primary care, using evidence-based practice. To aid this development SLaM will work with partners on finding IT solutions that limit the need for staff working across integrated systems to double entry on patient data bases.
- Active care plans will be shared across agencies including crisis plans to reinforce self-management behaviours and build confidence of service users to manage crises.
- All designs will have a solution to manage and routinely review community caseloads.
- All designs will have a generic CMHT at the centre providing continuity of care for the service user.
- Wherever possible there will be multi-agency, multi-professional working to break down barriers between teams and settings of care.
- Positive risk taking will be encouraged through multi-agency risk forums.
- All Community Services will define a set of performance and clinical outcome measures that will be agreed by the SLaM Quality Centre and Operations SMT to ensure the design is meeting the needs of the population and standards set by the red lines.
- All boroughs will be working to the principles as outlined in the Ten Year Plan.
- Boroughs will redesign their services iteratively on a road map defined by the relevant Alliance but working towards these principles.

iCare Model for Community Care in SLaM Boroughs

iCare is a trust wide Quality Improvement (QI) programme within the general adult care pathway (inpatient and community). It was set up in May 2017 in response to problems that were highlighted with inconsistency in the quality of care, and outcomes for people who use SLaM services. Whilst there were some areas of excellent practice, others required improvement. Too many patients are admitted outside of their local borough, significant variation in hospital length of stay was highlighted; with some significant delays in some areas, and teams were not always working at their best across boundaries with teams in other CAGs and with primary and social care.

Seven key principles, developed collaboratively underpin the approach, namely that iCare improvement work would:

1. Have clear sponsorship and leadership from senior clinicians and managers
2. Be co designed or co-produced with patients being at the centre and involve carers, staff and external stakeholders
3. Make systematic use of data to inform and test and change ideas for improvement
4. Ensure service users and staff feel are physically and psychologically safe to use and work in services
5. Provide opportunities for people to develop their knowledge and skills in QI methodology to enable them to test changes, share learning and scale up and spread successes.
6. Be supported by the Quality improvement and SLaM Partners (QISP) team, who have expertise in QI methodology (methods, tools, measurement, value) and psychological approaches to organisational development

7. Governed through weekly Icare meetings

The overall ICare aim agreed in May 2017 was:

For every patient to have a positive experience of SLaM with access to timely, high quality care, provided in a safe environment by services that are sustainably run. Through focussing on improving patient safety, standardising good practice and improving patient flow through services, by 2021

There are three workstreams:

1. Patient safety
2. Standardised ways of working
3. Patient flow and capacity

STANDARDISED WAYS OF WORKING

We want to ensure that the people who access our services experience the same standards of care no matter which borough they live in or which service they are under. Both the inpatient and community operational care process models (CPM) are being developed with service users, carers and staff so that people know the fundamental standards of care, namely standards of best practice (SBP), they can expect to receive in every ward and community team. The theory is that if we have SPB that these will reduce variation in practice and have a positive impact on patients receiving timely assessments and treatment thereby reducing need for admission, improving experience and achieving outcomes that matter to them. The operational standards for the SBP in the models below, have been developed in the context of Royal College of Psychiatrists’ Standards and learning from other mental health Trusts, Trust polices for good practice and national guidance. Furthermore, it has been informed and developed using Trust data and the outputs of the detailed care process maps produced with clinicians, service users and carers.

The aim therefore is:

For inpatient CPM that:

The patient experience and recovery journey is structured, purposeful, collaborative, safe and compassionate, taking into account complex needs and harm minimisation.

For the community CPM that:

Together with partners provide the community with easy access to the right mental health services, of the right quality, for the right length of time that meets their needs.

We will measure whether the inpatient and community CPMs contribute to making a difference to outcomes using the agreed set of outcome and process measures for ICare, including length of stay, number of admissions, readmissions with 30 days, adherence to SBP, patient experience and staff engagement and cost. Local and more specific ward/community improvement measures will be used in addition and will be determined based on the needs of local teams.

A Commitment to Involving and Consulting with Staff at the Outset (Floor to Board)

As the Trust embarks on its transformative journey across community services in 4 diverse London boroughs its impact will touch upon the careers of hundreds of our skilled and dedicated staff
members. From the outset it is recognised that our engine to drive serviced transformation is an involved, information and engaged workforce.

In recognising the four boroughs will move at a different pace the same delivery model with different implementation start dates will be rolled out. The initial workforce strategy sets out to develop a well-led and capable integrated workforce that is “… engaged, are striving to deliver the best possible care and support for the people of Borough served, are equipped to respond to the diverse communities we serve and are committed to achieving the Alliance and Partnership outcomes and upholding our principles.” We will achieve this by: developing innovative new ways of working; developing a positive workforce culture; ensuring the we have a capable workforce; providing authentic leadership; ensuring that we recruit and retain the best people, and; engaging the workforce and other stakeholders in the co-production of service design.

Borough Position Statements

Lambeth

In July 2018 the Lambeth Living Well Network Alliance came in to being, which means that the Trust’s working age services in Lambeth became formal partners with Certitude, Lambeth Clinical Commissioning Group, Lambeth Council, and Thames Reach. This formal partnership is based on a business case or plan that is committed to meeting the three big outcomes that were co-produced by Lambeth residents. These outcomes are for people living in Lambeth to: recover and stay well; be offered choice, and; participate on an equal foot in their daily lives.

In addition to delivering these three big outcomes for Lambeth residents, the priorities of the Alliance are to:

- reduce duplication of service delivery commonly experienced by service users and carers;
- reduce our current over reliance on inpatient mental health beds;
- tackle inequality experienced by communities;
- effectively meet the high level of need in the Borough, and;
- ensures value for money.

Current national guidance about the way mental health services are commissioned (i.e. bought from providers like the Trust) and delivered, requires a radically different approach. This guidance calls for models of integrated care delivery between partners, so that we can meet the physical, psychological and social needs of local residents. We will get better outcomes and value for money if we deliver care and support together. In regard to this national priority, Lambeth Alliance is an exemplar to moving towards an Integrated Care System.

Since the dismantling of the operational function aligned Clinical Academic Groups in the spring of last year Lambeth’s working age services have comprised of multiple community teams. This means that service users and carers are sometimes left navigating different entry points and can be subject to multiple hand offs before getting support and/or the treatment they need. In addition, we are left with a legacy of the majority of people with high level needs being treated by teams which only work with specific diagnostic groups. This has meant that some people have found themselves caught between different teams, and for other people they have more than one diagnosis, so again do not easily fit.

Over the last fifteen years the role of the community practitioner or care coordinator has dramatically changed with increased expectations of dealing with complex social issues which they are not trained to do. This has led to a bureaucratic burden, which is impacting on their capacity, ability to
be responsive and in some cases enjoyment of their work. There is also a legacy of individual caseload capping for practitioners, impacting on the flow of service users through the system and does not take into consideration complexity of caseloads.

Over the last 8 years there has been feedback from our communities that the whole system (not just the Trust) are sometimes failing to meet the needs of people from our diverse population, in particular, Caribbean and African communities. This is more broadly in regard to how we engage these communities, effective prevention strategies and providing care in the least restrictive way.

We are currently spending a large proportion of our mental health resource on acute mental health care. People using the acute part of the system are at risk of delayed discharge and lack alternative to admission and early discharge. This is impacting on the availability of beds to people in need of acute care and is resulting in financial pressures due to the use of private hospital beds. We need to enhance our community offer to provide alternatives to admission where appropriate, tackle delayed care and support early discharge, in other words a consistent system wide approach.

Finally, people will be well aware of the financial pressures health and social care is under. We need to ensure that we are spending our resources wisely and we will achieve more by entering into our formal partnership that has come together to provide integrated care.

**Proposed Changes**

Transforming mental health services in Lambeth requires a system wide approach due to the interrelationship between all the service offers. It also needs a huge shift in culture if we are going to achieve the big outcomes and address the challenges faced by the Borough.

The Living Well Network Alliance business case or plan has committed to developing three Living Well Centres (LWCs) that will be the organisational basis of most community based mental health services in Lambeth. Not in scope for change are Lambeth’s Home Treatment Team, IAPT, IPTT, Early Intervention Team and OASIS.

The centres will ensure that people have a straightforward system to access the correct mental health intervention and associated support in a timely manner.

The centres will be supported by a workforce consisting of health, social care and voluntary sector community staff who will work together in an integrated way to meet people needs and not as silo or separate services or functions.

**Staff Consultation**

The formal consultation process will run from Thursday 14th February 2019 for 30 days and finish at 9am on the Monday 18th March 2019.

A copy of Alliance Plans with proposed staffing structures will be sent to each affected member of staff to their email address to consult with them. Hard copies of the paper will be made available at the launch meeting scheduled for 9am Thursday 14th February 2018 at 332 Brixton Road. Any staff member on long term sick, career break, external secondment or maternity leave at this time will be written to at their home address with a hard copy of the paper.

A copy of this document will also been given to the Chair of Staffside together with an invitation to attend the scheduled open staff meetings. The meetings will be held to launch and close the
consultation process and staff affected, Staffside Chair and local trade union representatives are invited to attend.

During the consultation period affected staff has the right to be consulted with on an individual basis. These staff will be entitled to be accompanied by an accredited trade union representative or a work colleague.

Written comments regarding the new structures and way of working will receive due consideration and be responded to after the close of consultation. We anticipate the process for filling posts will commence on 25th March 2019 with the new arrangements coming into operation from 13th April.

<table>
<thead>
<tr>
<th>Event</th>
<th>Timetable, all 2019</th>
</tr>
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<tbody>
<tr>
<td>Consultation paper circulated</td>
<td>14th February</td>
</tr>
<tr>
<td><strong>Consultation formally commences</strong></td>
<td>14th February</td>
</tr>
<tr>
<td>First open staff meeting</td>
<td>14th February</td>
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<tr>
<td>(NB: any further open meetings should be included in this timetable)</td>
<td></td>
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<tr>
<td>Individual staff meetings</td>
<td></td>
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<tr>
<td>Consultation closes</td>
<td>9am 18th March</td>
</tr>
<tr>
<td>Respond to consultation feedback</td>
<td>25th March</td>
</tr>
<tr>
<td>Process for filling posts (where applicable)</td>
<td>25th March to 5th April</td>
</tr>
<tr>
<td>Decision communicated via outcome paper</td>
<td>8th April</td>
</tr>
<tr>
<td>New structure begins</td>
<td>Saturday 13th April</td>
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**Southwark**

SLaM will be front and centre in Partnership Southwark from the 1st April 2019. Partnership Southwark is a Local Care Partnership that bring together Partners in Southwark to deliver integrated care at a borough (‘place’) and neighbourhood level as part of the overall ‘System of Systems’ approach for South East London. Partnership Southwark will oversee work intended to develop integrated, high quality, affordable and sustainable health and social care services, which are delivered in the most appropriate way. Partnership Southwark is specifically dedicated to working as an alliance of organisations that collectively deliver services to shared outcomes for the population of Southwark (the Partnership). Partnership Southwark has brought together Partners from across Southwark to look at how health and social care services can be delivered more effectively.

Partnership Southwark intends to develop integrated, high quality, affordable and sustainable health and care services delivered in the most appropriate way as an alliance of organisations that collectively delivers services to shared outcomes for the population of Southwark. Supporting this vision, the Key Objectives are:

- Improved integration of physical health, mental health and social care for enhanced and equitable patient experience and outcomes and to support people to be as independent as possible
- Making the right thing the easiest thing to do for clinicians, patients and citizens in Southwark
- Designs and develops a new way of working across organisational boundaries for the benefit of patients developing a model that integrates the health and social care system including social care services such as primary prevention, primary and community care, acute and
specialist care, so that partners and specialist care so that partners can utilise the total quantum of their spend to meet population needs in an efficient and effective manner

- Define and agree neighbourhoods, cluster and borough level geographical areas, and the care models within them, for all partner organisations across Southwark and develop a new way of working across organisational boundaries for the benefit of patients by enabling integrated working and physical and mental health transformation
- Deliver more coordinated, integrated and personalised care orientated around a community sharing community data and resources
- Actively shift care closer to patient's homes and providing local community care where clinically appropriate and financially viable, maximising wellbeing, quality and safety
- Robust data sharing agreements between PS partners to enable both direct care and population health management and be flexible to include other partners when required
- Deliver performance and finance targets sustainably
- Encourage prevention, pro-active care, self-care and self-management across all partners and choosing priorities and ways of tackling together.
- Provide transformation resource Southwark-wide to develop integrated care model

**Priorities**

Partnership Southwark commit to working towards the shared strategic priorities during the year 2019-20 detailed below:

- Support and further development of the Neighbourhood mode
- Care Coordination for people with 3 or more LTC
- Improved primary care mental health
- Focused support for care homes and nursing homes
- Prevention & self-management linking to ‘Vital 5’
- Data sharing & Informatics.

For SLaM community teams works is well advanced on a new model of complex care and starting to take shape on an enhanced primary care model focussed on Assessment and Liaison. This will ensure primary care colleagues with SLaM community team support can get the right care to patients at the right time and reduce demand on secondary mental health services.

A summary of the key areas of work for implementation during Year One of Partnership Southwark are:

- Complex Care Southwark Move On Strategy
- SLaM Housing and Accommodation strategy
- Restructure complex care services
- Restructure panel processes
- Reduce overspend in placements
- Restructure Clozapine Clinic
- ICare Community Care Process Modelling
- Improved interface with primary care
- Reduction in admissions
- Increased access to crisis services

**Lewisham**

Design programmes with SLAM staff were launched late 2018. The initial programme concentrates on three specific areas. These are as follows:
**PCMHT development work stream**

Key tasks

- Explore neighbourhood-based MDT based PCMHTs.
- Managing demand – clarify threshold and capacity; establish triage & telephone triage
- Managing flow through whole system
- Joint working with GPs
- Delivering Advice & Consultation
- Managing Step down from Acute and Crisis Services

**Care pathways work stream**

Key tasks

- Development of condition specific care pathways informed by NICE guidelines but adapted to a neighbourhood PCMHT based service model
- Care pathways based on a Stepped Care model
- Care pathways that embrace whole team approaches such as Structured Clinical Management SCM & Contingency Management; joint delivery of psychosocial intervention
- Balancing neighbourhood PCMHT provision of Psychological Therapy and centralised secondary care provision – e.g. Bi-polar group programme; DBT & MBT groups
- Consultation to PCMHT MHPs regarding psychosocial intervention
- Delivery of Psychological Therapies- including specialist provision for patients who have a Borderline Personality Disorder diagnosis

**Continuing Care work stream**

Key tasks

- Can Promoting Recovery Teams extend their provision to other long-term conditions?
- What development will expanded teams require?
- How will PRTs mesh with other teams?
- How will PRTs with a broader remit manage demand, quality and flow?
- How will PRTs support step down to PCMHTs and Primary Care?
- Can PRTs benefit from the application of Structured Clinical Management?

Key features to be considered.

- **Neighbourhood** based MDT’s
- **Demand management** at GP practice level by GP practice based or linked Mental Health Professionals (MHP)
- Based on PRISM a shift from ‘referral’ to ‘**request for a service**’
- Joint **collaborative management** of patients where care is shared between GP and MHP
- Advice to a GP can be offered via a **consultation model** and may not require the patient to be seen by a MHP e.g. Medication management; Signposting to relevant services
- PCMHTs deliver interventions via **episodes of care** not via on-going Care Coordinator intervention – including benefits and housing support (if Social Care is integrated into a PCMHT)
- **PCMHT+** includes psychosocial intervention – Structured Clinical Management; Contingency Management; brief individual CBT; Family Intervention; Brief groups – Mood/emotion management; Mindfulness etc.
• Development of PCMHTs has been phased in some services – e.g. 1. MHP’s aligned to neighbourhoods 2. Devolvement of some secondary care provision to neighbourhood PCMHTs – e.g. medication clinics; physical health clinics; Psychological Therapy
• PCMHTs draw on models of Stepped Care – initial brief intervention before intensive treatment is considered.
• Balancing of Step up & Step down. Step up from Primary Care to PCMHT. Step down from PCMHT to Primary care. Step down from Acute & Crisis Services to PCMHT. Step up from PCMHT to secondary care long term care.

The findings from the work above will be summarised and presented to the Lewisham Executive in mid-March in preparation for beginning the transformation design work streams with alliance partners.

The approach thereafter is described in the Alliance Business Case which includes plans for user and carer involvement and co-production. The Business Case will be available for circulation and comment at the end of February 2019.

Proposed timeline for community transformation remains ‘model design and engagement’ completed by August 2019 with the first neighbourhood being “tested” in September 2019. Depending on the outcome of the testing a consultation will be launched January 2020 with the aim of cascading to other neighbourhoods beginning March 2020.

It is recognised that community transformation is likely to be an 18-month programme given the size and nature of the change combined with a need to manage risk with large volumes of service users. In addition, the timeline accounts for the need to undertake a thorough stakeholder and staff consultation.

Croydon

The design work in Croydon is two-fold:

• We are fully collaborating with the CCG to inform and shape the business case for mental health service provision in Croydon; and

• Simultaneously, we are in the very early stages of redesigning our services so that our secondary care offer is more responsive and effective

To date, we have identified:

• Challenges in accessing our services from primary care or other referral points due to the current structure and resource aligned to this service
• Challenges with flow throughout the community pathways
• Challenges in stepping people back to primary care

We will be commencing a GP advice line which will enable closer working with primary care colleagues, teams are embedding the use of a caseload weighting tool to support discussion re: interventions required to meet their needs and maximise opportunities for recovery and we are reviewing current resource and systems throughout the community care pathways to enhance flow.

Over the next 12 months we will focus on:

• The development of an enhanced primary care offer to support people access the right help at the right time in the right setting, including the development of a more robust response to crisis
We will be reviewing our current structures to determine areas for improvement and redesign required to be able to deliver condition specific NICE concordant treatments in a timely fashion.

We will also work with primary care and voluntary sector colleagues to support the move on from secondary mental health services.

The transformation programme for community mental services in Croydon transformation is anticipated to take 18 months from February 2019. This is due to the need to work collaboratively with all key stakeholders, in particular local authority and colleagues from the voluntary sector, along with Croydon CCG to align secondary mental health service changes with the programme of work being led by the CCG; both of which propose significant changes. This timeline also considers the requirement for thorough stakeholder and staff consultation.

**Current Resourcing Position by Weighted Population**

To deliver the ambitious community service plans in each borough the Trust will need to ensure that in a federated 4 borough model the Trust is (1) receiving a funding allocation to achieve financial balance in line with NHS regulator requirements; and (2) drawing in increased investment to align income and capacity with the London average as a minimum, and ideally with its London comparator Trust (NELFT).

2019-20 negotiations are focused on drawing in additional investment to develop community services and align locally commissioned capacity with demand. This will also help to deliver the Trust target of 32 days average length of stay and 85% occupancy as enhanced community services are able to support individuals with complex mental health needs in a community setting.

It is worth noting that plans to develop and achieve efficiencies in community services are in train across the 4 commissioning Boroughs and there is limited system resource to immediately shift an increase of circa £52m (London average) - £80m (NELFT) into the Trust baseline. Plans for growth will need to be phased over a 3-year period and fully align with the wider strategy for an integrated health system model across south London. Any increase in resource will need two levers and one enabler:

**Levers**

- Securing investment in line with the mental health investment plus an increase based on aligning to the London average for weighted spend over a 3-year period; and
- Working within an integrated provider model to deliver a shift of resource from acute into mental health crisis management and prevention (particularly liaison services) and community services

**Enablers**

- The transfer of commissioning budgets to provider collectives and alliance models to deliver improvements and efficiencies at scale. The Trust via SLP and new models of care, complex care and acute care programmes is in a strong position to take the lead on shaping these models. To note here as well CCGs have been asked to make 20% budget reductions in their corporate functions which will potentially reduce commissioning capacity and place a focus on Trust expertise in service development and resource allocation.

CCG financial allocations from NHS England which are then distributed to providers locally are based on a weighted population formula. In a perfect setting the spend allocated via this weighted allocation would transfer directly into an equal spend per head of population across London.

Across the four SLaM commissioning Boroughs the breakdown of weighted spend per head of population is:
SLaM

<table>
<thead>
<tr>
<th>Borough</th>
<th>Additional annual allocation per person required to align with London average</th>
<th>Financial differential when applied to weighted total population of Boroughs</th>
</tr>
</thead>
<tbody>
<tr>
<td>Croydon:</td>
<td>£37 / 25%</td>
<td>£18.4m</td>
</tr>
<tr>
<td>Lambeth:</td>
<td>£34 / 23%</td>
<td>£23m</td>
</tr>
<tr>
<td>Southwark:</td>
<td>£15 / 10%</td>
<td>£7.5m</td>
</tr>
<tr>
<td>Lewisham:</td>
<td>£12 / 8%</td>
<td>6.3m</td>
</tr>
<tr>
<td>Average:</td>
<td>£25 / 17%</td>
<td>Total differential: £55.2m</td>
</tr>
</tbody>
</table>

Using NELFT as a comparator mental health provider based in North East London there is a 25% differential which equates to £81m.

Community Caseloads

When compared to other London Trusts SLaM (MH09) has the third lowest capacity in London to manage community caseloads as indicated below. The Trust has a total community caseload of 822 in comparison to the London average of 1,340 and NELFT community caseload of 1,825\(^1\) per 100,000 weighted population. There is a capacity gap of 518 patients or 39% to London average and 1,003 patients or 55% in comparison to NELFT.

---

\(^1\) Data from Healthy London Partnerships Mental Health Dashboard - [http://lmh.nhsbenchmarking.nhs.uk/toolkit](http://lmh.nhsbenchmarking.nhs.uk/toolkit)
The SLaM community caseload per Borough at end November 2018 is set out below.\(^3\)

\(^2\) Unless otherwise referenced all data is taken from the NHS Benchmarking Tool. SLaM is referenced as MH09 in this dataset, London Trust as the green bar and all other UK mental health Trusts as the blue bar

\(^3\) Source Deming Trust Dashboard November 2018
When compared to the London average for community caseloads of 1,340 and NELFT community capacity of 1,825 there is a capacity gap per borough of:

<table>
<thead>
<tr>
<th>Borough</th>
<th>Capacity Gap to London Average</th>
<th>Additional income required to achieve London average (based on SLaM average community caseload cost per patient of £4,100)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Croydon</td>
<td>633 patients / 47%</td>
<td>£2,595,300</td>
</tr>
<tr>
<td>Lambeth</td>
<td>822 patients / 61%</td>
<td>£3,370,200</td>
</tr>
<tr>
<td>Lewisham</td>
<td>674 patients / 50%</td>
<td>£2,729,260</td>
</tr>
<tr>
<td>Southwark</td>
<td>637 patients / 48%</td>
<td>£2,880,960</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Borough</th>
<th>Capacity Gap to NELFT</th>
<th>Additional income required to achieve NELFT (comparator Trust) activity levels (based on SLaM average community caseload cost per patient of £4,100)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Croydon</td>
<td>1,118 patients / 61%</td>
<td>£4,583,800</td>
</tr>
<tr>
<td>Lambeth</td>
<td>1,307 patients / 72%</td>
<td>£5,358,700</td>
</tr>
<tr>
<td>Lewisham</td>
<td>1,159 patients / 64%</td>
<td>£4,751,900</td>
</tr>
<tr>
<td>Southwark</td>
<td>1,122 patients / 61%</td>
<td>£4,600,200</td>
</tr>
</tbody>
</table>

**Workforce Challenges and Actions**

Any additional income or resource shift into community services can only be delivered by a strategic approach to the community service model and workforce modelling to ensure that the Trust can make the shift into any new model at pace that ensures quality is protected and enhanced with staff enabled and supported to make the change.

As the Trust enters 2019/20 contract negotiations the focus clearly needs to be on drawing in additional income to ensure capacity of community services is funded to meet demand levels in the context of a low bed base.

To deliver a realistic plan the income strategy should be over three years in a phased approach with a target to achieve a 17% uplift / £52m increase in resources above baseline / annual uplift.

By borough this equates to:

<table>
<thead>
<tr>
<th>Borough</th>
<th>Year 1</th>
<th>Year 2</th>
<th>Year 3</th>
</tr>
</thead>
<tbody>
<tr>
<td>Croydon</td>
<td>£6.1m</td>
<td>£6.1m</td>
<td>£6.1m</td>
</tr>
<tr>
<td>Lambeth</td>
<td>£7.7m</td>
<td>£7.7m</td>
<td>£7.7m</td>
</tr>
<tr>
<td>Lewisham</td>
<td>£2.5m</td>
<td>£2.5m</td>
<td>£2.5m</td>
</tr>
<tr>
<td>Southwark</td>
<td>£2.1m</td>
<td>£2.1m</td>
<td>£2.1m</td>
</tr>
</tbody>
</table>

In aligning the above income to funding required to achieve NELF levels of community capacity the following internal allocation would be required:

<table>
<thead>
<tr>
<th>Borough</th>
<th>Year 1 Community Allocation</th>
<th>Year 2 Community Allocation</th>
<th>Year 3 Community Allocation</th>
</tr>
</thead>
<tbody>
<tr>
<td>Croydon</td>
<td>£1,527,933</td>
<td>£1,527,933</td>
<td>£1,527,933</td>
</tr>
<tr>
<td>Lambeth</td>
<td>£1,786,233</td>
<td>£1,786,233</td>
<td>£1,786,233</td>
</tr>
<tr>
<td>Lewisham</td>
<td>£1,583,967</td>
<td>£1,583,967</td>
<td>£1,583,967</td>
</tr>
<tr>
<td>Southwark</td>
<td>£1,533,400</td>
<td>£1,533,400</td>
<td>£1,533,400</td>
</tr>
</tbody>
</table>
REPORT TO THE TRUST BOARD:  PUBLIC
26 February 2019

Title | The Quality Centre – Next Steps
---|---
**Author** | Dr Michael Holland, Medical Director
**Accountable Director** | Dr Michael Holland, Medical Director, and Beverley Murphy, Director of Nursing

**Purpose of the paper**

(1) To discuss and note the progress and development of the Quality Centre
(2) To agree on the direction of the development of the Quality Centre

**Executive summary**

The purpose of the Quality Centre is to develop and monitor pathways and outcomes across the trust to reduce the variation between boroughs and clinical teams to improve care. The Quality Centre incorporates the functions of the CAGs within it and therefore depends on the close alignment of the Academic Directors and Clinical Directors to translate the evidence base into practice. Over the last year 6 areas of work have been focussed on:

1) The development of improvement plans for priority areas identified by the CAGs where there is evidence that there is a gap between clinical service delivery and the evidence base – examples are given in the table below.
2) Developing a structure and process to approve research applications across the organisation – see Appendix 1. This is now in operation.
3) Aligning CAG Research plans with the R&D strategy.
4) Developing training and education plans for each CAG. These are currently being formulated.
5) Developing the approach for the best way to integrate QI into the newly formed CAG namely the Quality Improvement and Implementation CAG (Clinical Director – Dr Hugh Jones, Academic Director – Prof Nick Sevdalis/ Dr Claire Henderson, QI Director – Dr Barbara Grey).
6) Planning infrastructure to support delivery of Quality Centre – we are currently looking to recruit to four posts: Senior information/data analyst post, project manager, senior administrator/business manager, administrator.

Over the coming year the Quality Centre will need to maintain its focus on continuing to deliver this and develop in 3 further areas:

1) The integration of the Trust’s Clinical Governance functions
2) The integration of the information approach.
3) The integration of the quality centre with future commissioning arrangements.

**Timeline:**

April 2019 – Delivery of information strategy and integration in Quality Centre
May 2019 – appointed to support roles for Quality Centre
August 2019 – Review completed of clinical governance function and integration of clinical governance into Quality Centre
December 2019 – Structures and systems for Quality centre working with commissioning role.
1. **Purpose of the Quality Centre**

The purpose of the Quality Centre is to develop and monitor pathways and outcomes across the trust to reduce the variation between boroughs and clinical teams to improve care. The Quality Centre will then continuously monitor the delivery of the pathways and improve these through a Plan, Do, Study, Act (PDSA) cycle. The Quality Centre needs to be able to position itself to be able to work directly with the operational commissioners and strategic commissioners to inform and direct the design of the local services. There will need to be close working understand local population needs to be able to inform the design of services to improve outcomes at a population level.

The Quality Centre will also include education and development and R&D to ensure that clinical development supports the improved processes and that R&D is encouraged within Operations Directorates. The Quality Centre is responsible to the Medical Director and the Director of Nursing and will contain the CAGs and CAG business support functions. It will assist the CAGs through a senior management team made up of the leaders of all the functions within the Trust. The Service Directors will work with the Quality Centre to ensure operational issues are taken into account when designing pathway improvements and to ensure consistent implementation of pathways. In this way the Quality Centre senior management team can direct the resources within the Trust to support pathway development and service improvement across all CAGs and all Operations Directorates. Currently the structure is shown below. The Quality Centre will be a unique hub bringing together clinical and “expert by experience” working in partnership to deliver our quality Improvement projects. The Centre will build the capacity of service users, carers and staff to participate effectively in QI projects through a programme of incremental learning and development utilising the Ladder of Participation. The programme will train clinicians and service users/carers together so that equal participation and stake holding is built into the process from the start. However, given the changes there will be a need to strengthen the operational leadership of the quality centre in order to rapidly put all its functions in place and operate effectively across the organisation.

A simplified Quality Centre structure is shown below.
Current progress of the Quality Centre

The quality centre (QC) of which the QI team is a part, is led by the Medical Director and Director of Nursing with a small MDT and brings together:

- 7 Clinical academic groups (CAGs)
- Input from operational directorates
- QI team
- Outcomes group
- Professional Heads
- Research and development

Since its inception in September 2018, there has been a focus on 6 areas:

1) The development of improvement plans for priority areas identified by the CAGs where there is evidence that there is a gap between clinical service delivery and the evidence base – examples are given in the table below.

2) Developing a structure and process to approve research applications across the organisation – see Appendix 1. This is now in operation.

3) Aligning CAG Research plans with the R&D strategy.

4) Developing training and education plans for each CAG. These are currently being formulated.

5) Developing the approach for the best way to integrate QI into the newly formed CAG namely the Quality Improvement and Implementation CAG (Clinical Director – Dr Hugh Jones, Academic Director – Prof Nick Sevdalis/ Dr Claire Henderson, QI Director – Dr Barbara Grey).

6) Planning infrastructure to support delivery of Quality Centre – we are currently looking to recruit to four posts: Senior information/data analyst post, project manager, senior administrator/business manager, administrator.

Examples include:

<table>
<thead>
<tr>
<th>CAG</th>
<th>Priority area for improvement</th>
</tr>
</thead>
<tbody>
<tr>
<td>Quality Improvement and Implementation CAG</td>
<td>The aims of the improvement project are 1) to have no breaches of &gt; 4 hours in emergency</td>
</tr>
<tr>
<td></td>
<td>departments of patients presenting with mental health problems or crises and are assessed as</td>
</tr>
<tr>
<td></td>
<td>requiring either admission or at least an extended inpatient assessment to more fully consider</td>
</tr>
<tr>
<td></td>
<td>patient needs. 2) to ensure that local SLAM beds are always available to receive such patients to</td>
</tr>
<tr>
<td></td>
<td>avoid the use of private sector beds for this patient cohort</td>
</tr>
<tr>
<td>Psychosis</td>
<td><strong>Problem:</strong> The NICE guidelines state that if a patient with psychosis has not responded to two courses of antipsychotic treatment they are 'Treatment Resistant' and should be offered treatment with Clozapine.</td>
</tr>
<tr>
<td></td>
<td>A course of antipsychotic treatment takes 1-2 months to complete. Therefore, it should be possible to determine whether a patient is 'Treatment Resistant' within the first year of presentation with psychosis, when the patient is still under the care of early intervention services.</td>
</tr>
<tr>
<td></td>
<td>However, data from SLAM show that the average time between first presentation with psychosis and being offered Clozapine is 8.5 years (Howes et al, 2012). Moreover, during this period, rather than receiving Clozapine, these patients are often treated with multiple antipsychotic drugs and/or doses of antipsychotics that exceed BNF maxima.</td>
</tr>
</tbody>
</table>
of which are evidence-based or recommended.

Clinicians may be reluctant to prescribe Clozapine because they believe that it is associated with severe side effects and increased mortality. However, a study of 15,000 patients with psychosis in SLAM found that patients treated with Clozapine had a better life expectancy than patients treated with conventional antipsychotics, even though those treated with Clozapine were more severely ill (Hayes et al, 2014).

The cost of managing patients who are unresponsive to antipsychotic treatment is up to 11 times more than that for patients who respond to treatment (Kennedy et al, 2014). These costs could be substantially reduced if this subgroup were identified earlier and offered the appropriate treatment sooner.

**Aim:**

To increase use of clozapine in the group of patients under EI services with treatment resistant schizophrenia at an earlier stage. To increase from 0.5-1% prescribed to 5% over 12 months

**Plan to achieve aim:**

Plan at present in place is engage each EI team, sharing the data and the draft aim and work plan. It is suggested that the Psychosis CAG work with the clinical directorates using the collaborative methodology (attached) to then set up a testing and improvement plan for improvement involving service users and carers and staff to do the work.

---

**Older adults- Memory service**

**Problem:**

Variation in waiting times for first assessment across SLAM Memory Services with particularly long waits in Croydon.

Directorate Mortality reviews have noted people relatively large numbers of deaths of people on Croydon Memory Service waiting list.

NHSE implementation guide states ambition to increase proportion of people referred for dementia assessment diagnosed and starting treatment within 6 weeks of referral. London Network and local CCGs are setting timelines and more specific ambitions for waiting times.

Variation in practice in terms of neuroimaging and ECG investigations as part of diagnostic process across the three services.

New NICE guidance and forthcoming London Network document clarifies the neuroimaging pathway.

Need to update our MHOAD care pathway on dementia to align with new NICE guidance and other new evidence.

Staff in the teams have told us that they have felt “micro-managed” about these issues.

**Aim: To reduce wait times from receipt of referral to first intervention and then to diagnosis to 6 weeks and under for 85% of patients by April 2021**

**Plan in place to achieve Aim:**

Memory Collaborative started in October 2018. Two learning events have taken place with all teams and each team has been supported by a QI coach and sponsor, testing change ideas, sharing learning and now testing in different conditions. Wait times are reducing and teams continue to focus on improving aspects of the care pathway to enable...
them to continue to improve outcomes that matter to patients.

PMIC CAG- Bi-polar  We aim to ensure that patients in our PMIC CAG community teams can be offered an improvement in the identification of their illness and its acute and preventative treatment, better continuity of care, education about bipolar disorder and effective self-management strategies.

**Next steps:**

In order for the quality centre to deliver the outcome of continually improving the outcomes for our services, it will need to integrate quality governance for the organisation and the informatics capability so that a quality system can be delivered which cover the 3 aspects of quality improvement, quality control (assurance) and quality improvement.

![Triangle Diagram]

Therefore, we will also be integrating the Trust clinical governance function into the quality centre to work more closely with quality improvement. A paper about the quality management system will be coming to the Board in the near future.

Delivery of the information strategy will also be a critical aspect to the working of the quality centre to allow it to be able to monitor performance of care processes (e.g. the delivery of the research evidence into clinical care) and outcomes (safety metrics, clinical outcomes and patient experience) for our services. Therefore, we will be considering how the BI and Informatics function works closely and integrates into the Quality centre in order to support it function. Working with both BI and the BRC datasets to evaluate the population needs will be developed to allow for the design of services to meet local needs.

**Quality Centre Evolution of Commissioning Function**

Regardless of the commissioning model be it activity-based, alliance-based or outcomes-based, there is always a requirement for a clinical pathway specification i.e. the detail of the care and standards expected of a pathway procured by whatever commissioning model is in place. Under traditional activity based commissioning the pathway specification function is completed by the CCG, but as we move to alliance and outcomes-based commissioning the function begins to move towards the provider or clinical expert organisation.

When required, the Quality Centre is the body in SLaM that will authorise clinical pathway specifications. How the Quality Centre operates will depend on the commissioning model at the time, for example:

**Alliance models.** Clinical pathways will be designed with alliance partners and co-produced with relevant alliance members to meet the needs of the alliance. The Quality Centre will authorise all clinical pathway specifications for SLaM services to ensure they meet best practice and clinical guidelines and only exhibit variation within acceptable tolerance. The Quality Centre will then monitor the service delivery to ensure it meets the service specification and the clinical and quality standards.

**Outcomes-based commissioning.** A strategic commissioner, whether in an alliance or not, will specify the outcome for a population or condition, the quality centre will be able to work to make these outcomes quality focussed KPIs to reflect outputs of increased investment. The Quality Centre will produce the
clinical pathway specification that SLaM will use to achieve that outcome and operationally commission SLaM Directorates to deliver it. The Quality Centre will then monitor the service delivery to ensure it meets the service specification and the clinical and quality standards.

In this way the commissioning function of the Quality Centre remains to authorise or produce clinical pathway specifications which may either be commissioned by the Quality Centre or an alliance.

There is very positive commitment in SEL to develop a new Mental Health Commissioning / Quality Framework with the transfer of responsibilities and work is underway to establish a Programme Board / Gateway Process to agree and oversee the detail of this work linked to our emerging Integrated Care System.

As partner organisations in the South London Partnership, SLaM and Oxleas are agreed that these discussions offer our SEL health system the immediate opportunity to move towards a model of Outcomes Based Commissioning, stripping out redundant reporting and service specifications; and the opportunity to focus on the higher-level population outcomes that we are jointly signed up to in our emerging partnerships and alliances. We have learning from New Models of Care in the transfer of commissioning budgets to deliver service improvements and efficiencies.

The transfer of Mental Health Commissioning responsibilities during 2019/20 would enable us to deliver innovation in taking forward our Integrated Care System, deliver back office efficiencies and support delivery of a one channel approach to regulator assurance and reporting compared to the current multi-channel approach. Another key benefit would be the application of a standardised population health-based model with outcomes and performance metrics linked to delivery of the NHS long term plan with local nuances. The clinical expertise for improving quality and care standards that sit within the Quality Centre would be a new innovation and make use of best in class research and new models of patient care.

**Timeline:**

April 2019 – Delivery of information strategy and integration in Quality Centre
May 2019 – appointed to support roles for Quality Centre
August 2019 – Review completed of clinical governance function and integration of clinical governance into Quality Centre
December 2019 – Structures and systems for Quality centre working with commissioning role.

Beverley Murphy and Michael Holland will be reviewing the development on a monthly basis.

**Appendix 1: How does the quality centre link to R&D activity?**

This process will need to dovetail with the final agreed systems for implementation and assurance of care pathways and teaching delivery.

In the meantime, R&D delivery can be conceptualised as a quasi-commissioning process. The CAGs will drive delivery of contracted (funded) research through liaison with the Operational Units. This will follow the steps below:
- CAGs help set research priorities for the Trust through the R&D Committee
- CAGs will approve capacity for funded research and liaise with Operational leads to agree implementation/delivery strategies (e.g., rate of recruitment expected; teams to recruit from first, etc) (see page 2/3)
- CAGs will review this through receiving
  - recruitment data to time and target per project (from R&D)
  - KPI adherence (from Operational units) (see list below)
  - mapped activity by borough and clinical team (data from R&D)
  - Job planning data re R&D (Operational units)
- CAGS will approve distribution of recruitment related R&D funding to reward past recruitment and incentivise future recruitment.
- CAGS will feed back information regarding ongoing/open research projects, and completed research outcomes to the operational delivery units in keeping with the R&D Comms Strategy.

Note: Excess Treatment cost process is under revision: - Lead R&D Office will review Portfolio-eligible applications and complete a costing template tool (SoECAT) for all applications that have ETCs.

SLaM threshold is £19,284 for Q3&4 of 2018/19 and £38,567 for 2019/20 for CCG-funded ETCs (specialist funded by NHSE). Other sites advised of ETC rate post award. CRN will pay Trusts once Trust threshold exceeded on a per patient basis, directly from recruitment activity.
R&D KPIs

- Number of clinical teams in CAG not involved in any research project (aiming for 0!)
- NIHR Portfolio studies running (n)
- NIHR portfolio recruitment activity (n)
- Commercial studies running (n)
- Commercial study recruitment activity (n)
- Non-Portfolio studies running (n)
- Non-Portfolio recruitment activity (n)
- SLaM-employed Principal Investigators
- Staff with research protected time identified in job plan
- C4C metrics
R&D and the new SLaM structure

Quality Centre

CAGs

Develops and commissions quality standards for the operations directorates to implement as detailed, quality processes that give clear outcomes

Operations Directorates

Delivery of care

Makes sure that clinical development supports the improved processes and that research and development is delivered within operations directorates

R&D KPIs

- Number of clinical teams not involved in any research project (aiming for 0!)
- NIHR Portfolio studies running (n)
- NIHR portfolio recruitment activity (n)
- Commercial studies running (n)
- Commercial study recruitment activity (n)
- Non-Portfolio studies running (n)
- Non-Portfolio recruitment activity (n)
- SLaM-employed Principal Investigators
- Staff with research protected time identified in job plan
- C4C metrics
Approval for research taking place in SLaM clinical services within the new Trust structures

1 Previous arrangements for approval

The current arrangement for approval of research projects wishing to access Trust clinical services is through individual review by the relevant CAGs. Each CAG is asked to review capacity and capability to accommodate a proposed project, with slightly different internal processes depending on the CAG. Decisions are usually turned around within a month.

2 New arrangements for approval

Within the new Trust structures we propose that clinical services’ capacity and capability to accommodate research projects is considered as follows:

(a) For the Adult Mental Health CAGs (Psychosis, PMIC, Pathway Integration) as well as Specialist / National services, a single combined approval panel is formed that would include representation from the CAGs and the Borough Operations Directorates:
The membership of the combined panel would include the Clinical and Academic CAG Directors (Psychosis, PMIC and Pathway Integration) and a representative from each of the relevant Operations Directorates (Service Director, Deputy Director, Head of Nursing, Medical Lead). It is proposed that the panel be chaired by the R&D Director and that the panel would meet at least monthly so as to ensure timely decision-making within R&D time lines that are measured nationally.

Requests for approval would be submitted to R&D, distributed to the single combined panel, and discussed at the next committee meeting. A relevant CAG lead would be nominated to present the project details at the next approval meeting. Approval and recruitment strategies to be agreed at that meeting and communicated to the Principal Investigator.

Costs to support the new combined system for adult mental health will need to be quantified and put into a 2019/20 business plan.

(b) For CAMHS, MHOAD, Addictions and BDP CAGs we propose that each CAG individually continues with their existing R&D review processes as there are overlapping personnel at director level between the CAGs and the Operations Directorates:
REPORT TO THE TRUST BOARD: PUBLIC
26 February 2019

Title | Capital, Estates and Facilities dashboard
--- | ---
Author | Matthew Neal – Director of CEF
Accountable Director | Altaf Kara – Director of Strategy and Commercial

Purpose of the paper

1. This paper is brought to the board for information and discussion. The board is asked to feedback any changes it would like to see in future submissions.

2. The board is asked to note the contents.

Executive summary

The dashboard and summary paper show estates performance in key areas in the year to date up to M09 FY18/19:

The key points from the dashboard are:

- The cumulative estates & capital project spend to date at M09 FY18/19 (excluding IT, Douglas Bennett House (DBH) & Children and Young Persons Project (CYP)) is 40.5% of plan with a year-end projected variance of £12,005k or 58.39% of plan.

- Key drivers of this variance in M09 relate to the lack of suitable decant space necessary to enable ward refurbishment works in year, the strategic decision to competitively tender all window replacement schemes and ongoing negotiations with a third party in relation to a community scheme.

- The operating budget for the Directorate shows an in-month variance of £67k, 0.30% under budget with a year-end forecast of £30,179 – a variance of £343k at 1.15% over budget.

- 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 M07 to M09 and team has again confirmed that no genuine Priority 1 calls were left unresolved outside of the agreed KPI’s.

- Overall compliance performance continues to be strong despite some headline performance drops driven by late submission of associated documentation. Where there have been minor derogations the team has mitigation plans in place to rectify in the next period.

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 a new Head of Capital Projects due to commence employment on the 1st April 2019.

The paper also reports on the Douglas Bennett House and Children and Young Persons projects, updating the current contractual and design development position as of M09 FY18/19.

A supplementary Part 2 paper provides further updates on the FY18/19 Disposal programme.
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

Committees where this item has been considered

<table>
<thead>
<tr>
<th>Date</th>
<th>Committee / Meeting</th>
</tr>
</thead>
<tbody>
<tr>
<td>25 February 2019</td>
<td>Finance and Performance Committee</td>
</tr>
</tbody>
</table>

This paper provides expanded commentary to the February 2019 CEF Dashboard Performance report to provide detail and further narrative on the department’s performance to M09.

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</td>
<td><strong>April 2018</strong>: Follow up on gap analysis exercise to identify key third party landlords with outstanding compliance information.</td>
</tr>
<tr>
<td>Trust are a tenant to a third-party landlord.</td>
<td><strong>June 2018</strong>: All landlords have been written to including full request of any outstanding information, no responses to date. Requires escalation.</td>
</tr>
<tr>
<td></td>
<td><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></td>
<td><strong>February 2019</strong>: Responses have been submitted and the information sent back is being reviewed by the team to ensure compliance.</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.</td>
</tr>
<tr>
<td></td>
<td><strong>June 2018</strong>: Gleeds have been appointed to undertake this work to be progressed in July 2018.</td>
</tr>
<tr>
<td></td>
<td><strong>November 2018</strong>: This has been completed.</td>
</tr>
<tr>
<td></td>
<td><strong>February 2019</strong>: Part of operational compliance processes and embedded in team policy and process.</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.</td>
</tr>
<tr>
<td></td>
<td><strong>June 2018</strong>: Additional interim delivery and management resource has been established whilst recruitment of full time roles is completed.</td>
</tr>
<tr>
<td></td>
<td><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></td>
<td><strong>February 2019</strong>: Two new project managers have been recruited; one Project Manager has already started and the other due to join in March 2019. The Head of Capital will join the Trust on April 1st.</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.</td>
</tr>
<tr>
<td></td>
<td><strong>June 2018</strong>: Actions underway, linked to the update of...</td>
</tr>
</tbody>
</table>
the Community Estate Strategy. Live in Guardians engaged to protect vacant properties.

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Douglas Bennett House (DBH):

- Stage 3 contract has been signed with IHP to take the Trust through to the end of the FBC process.
- This includes detailed design stage and formalisation of GMP.
- Work has started on the development of the FBC and planning for the pre-consultation business case.
- NHSI discussion is planned to verify their anticipated process and negotiate a smooth way through the regulatory necessities.
- Since the start of stage 3 there has been a material increase in the rate of expenditure because of the work IHP require to undertake to complete the detailed design and full technical and mechanical procurement processes.
- The spend to date in FY18/19 at M09 on this scheme is £741k

Chart 2: Strategic Capital Schemes Update: Cost & Cashflow at M09 FY18/19

Following the progress noted above in Chart 1 several actions are required before robust cash flow projections can be ascertained:

**DBH:**

- Confirm programme approach with NHSI, engagement is currently being progressed.
- Develop full FBC.

**CYP:**

- Progress design with supply chain partner (IHP) and KCL.
- Develop full FBC

The delivery team will continue to update the Trust Executive through existing reporting channels with future Board reports to include updated cashflow projections once the above activities have been completed.
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- M09 cumulative position is £5,277k, a variance of £7,755k or 59.50% of the plan.
- Forecast spend to year end is £8,552k, a variance of £12,005k or 58.39% of the plan.

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- 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.
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- The Trust has now appointed a new Head of Capital Projects who is due to commence employment on the 1st April 2019.
- The team are in the process of tendering a refreshed consultant advisory team, with appointments expected in April 2019.
- A revised 24-month programme for FY 19/20 and 20/21 has been reviewed by the Capital Review Group and under consideration by the Ops SMT.

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:

- CAMHS PICU (£376k): Driven by significant asbestos issues in the services ducts to the Tyson house portion of the works, leading to further delays and cost overruns.

Chart 5: CEF Departmental: Operating Budget Spend Against Plan M09 FY18/19:

Since the M02 FY18/19 Trust Board report the CEF Departmental Budget has been re-baselined for FY18/19 to allow for pay uplifts, utilities inflation and the uplift to the ISS contract (Catering and Domestic).

- M09 YTD actual spend is £22,359k, a variance of £67k or 0.30% under plan.
- M09 in-month actual spend is £2,430k, a variance of £39k or 1.57% under plan.
- M09 variance caused by the transfer of some backdated funding from services relating to the contractor’s cleaning of additional community sites. There were further backdated credits for KPIs and carpet cleaning received from the contractor (ISS) in M09.
- Forecast spend to year end as of M09 is £30,179k, a variance of £343k or 1.15% above plan.
- The forecast year end overspend is principally caused by the ongoing dispute with NHS Properties regarding unfunded rent increases, but also the delay in implementing the new car parking payment system which has had an adverse effect on the income that was forecast to be received at the beginning of the year.

Chart 6: Estates: M09 In Month Reactive Call Response Rate % YTD FY18/19:

- M09 Priority 1 (1-2 Hour Response & Close Out): 4 of 6 jobs closed within KPI (67% target 90%)
- M09 Priority 2 (2-4 Hour Response & Close Out): 8 of 18 jobs closed within KPI (44% target 90%)
- M09 Priority 3 (2 Day Response & Close Out): 1,496 of 1,802 jobs closed within KPI (83% target 70%)
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- Erroneous raising of calls to the Priority 1 code and the ability of the site teams to close out the legitimate calls on the system within the KPI time window, despite addressing the underlying issue, continues to drive the reporting issues.
- The Estates team is in the process of setting up an auto-generated report to be circulated to all site staff and have re-communicated the Priority code definitions to the administrative teams to alleviate future erroneous coding.
- The team are confident that a more transparent, and regular, system of internal reporting should lead to improved reporting accuracy and more robust KPI data in future reporting periods.

Chart 7: Estates: Compliance Risk Assessment Completion M09 FY18/19:

**Air – Specialist Extract**
- **Performance:** 33.33% - Deviation driven by 3 locations, all scheduled to be inspected in Jan/Feb 2019.
- **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:** No Comment Required as 100% Compliant.
- **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:** 65.77% - Deviation driven by Electrical Plant Assurance 33 sites have been visited. Awaiting documentation.
- **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.

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• **Assurance:** Independent auditor (RM Associates, Dr Jane Tinkler). Water Risk assessments updated every two years, water coolers sanitised on a six-monthly basis.
**SLaM Trust Board – CEF Dashboard Commentary Paper**

26th February 2019

Prepared by Matthew Neal

**Introduction & Context**

This paper provides expanded commentary to the February 2019 CEF Dashboard Performance report to provide detail and further narrative on the department’s performance to M09.

**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>
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| Visibility on the condition of the whole Estate, particularly where the Trust are a tenant to a third-party landlord. | April 2018: Follow up on gap analysis exercise to identify key third party landlords with outstanding compliance information.  
June 2018: All landlords have been written to including full request of any outstanding information, no responses to date. Requires escalation.  
November 2018: Follow up letters have been sent to all parties. A review of responses will be undertaken in month and escalated where appropriate.  
February 2019: Responses have been submitted and the information sent back is being reviewed by the team to ensure compliance. |
| Independent assurance of statutory Estate compliance.                  | April 2018: Engage a third party to review the in-house team assurance processes and data.  
June 2018: Gleeds have been appointed to undertake this work to be progressed in July 2018.  
November 2018: This has been completed.  
February 2019: Part of operational compliance processes and embedded in team policy and process. |
| Delivery of FY18/19 Capital & Revenue Plans given divergence in FY17/18. | April 2018: Continued implementation of TIAA and GSTT audit recommendations in addition to prevailing turnaround activities and resource stabilisation.  
June 2018: Additional interim delivery and management resource has been established whilst recruitment of full time roles is completed.  
November 2018: Two new internal Trust Project Managers have been recruited and the Head of Capital role is to be interviewed in November 2018.  
February 2019: Two new project managers have been recruited; one Project Manager has already started and the other due to join in March 2019. The Head of Capital will join the Trust on April 1st. |
| **Delivery of FY18/19 Disposal Programme.** | **April 2018:** Adherence to Disposal audit recommendations and revision of internal processes and gateway checks.  
**June 2018:** Actions underway, linked to the update of the Community Estate Strategy. Live in Guardians engaged to protect vacant properties.  
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CEF Directorate Performance Overview at M09 FY18/19

*M09* FY18/19

**Douglas Bennett House (DBH) and Children & Young Persons (CYP):**
- Stage 3 contracts of the P21+ process have now been signed and will allow the Trust to proceed to FBC for DBH.
- IHP have been engaged to undertake initial design stage for CYP which will involve input from SLaM, KCL and Maudsley school staff.
- See narrative portion of paper for further information.

**Chart 1 Strategic Capital Schemes Update: Programme & Spend at M09 FY18/19**

**Chart 2 DBH: Cumulative Cash Flow YTD M09 FY18/19**

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

<table>
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<th>Original Budget (CRG/SMT Date)</th>
<th>Revised Cost 1 (CRG/SMT Date)</th>
<th>Revised Cost 2 (CRG/SMT Date)</th>
<th>Revised Cost 3 (CRG/SMT Date)</th>
<th>Revised Cost 4 (CRG/SMT Date)</th>
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**Chart 5 Capital Planning: Cumulative Capital Planning & Status (Excluding Strategic and IT) Spend Against Plan M09 YTD FY18/19**

**Chart 7 Estates: Compliance Risk Assessment Completion M09 FY18/19**
REPORT TO THE TRUST BOARD: PUBLIC
26 February 2019

Title                  | Finance Report as at 31 January 2019
---                    |-----------------------------------------
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 January 2019 (month 10). The summary financial statement and calculation of the Use of Resource rating from the NHSI Month 10 submission is attached to the report in Table 2.

A summary of the changes in the financial forecast can be found in the table below:

<table>
<thead>
<tr>
<th></th>
<th>Plan 31/03/2019 Year ending £'000</th>
<th>Forecast 31/03/2019 Year ending £'000</th>
<th>Variance 31/03/2019 Year ending £'000</th>
</tr>
</thead>
<tbody>
<tr>
<td>Adjusted financial performance surplus/(deficit) excluding PSF</td>
<td>2,506</td>
<td>13</td>
<td>(2,493)</td>
</tr>
<tr>
<td>Adjusted financial performance surplus/(deficit) excluding PSF</td>
<td>(3,181)</td>
<td>(2,067)</td>
<td>1,114</td>
</tr>
<tr>
<td>Adjusted financial performance surplus/(deficit) excluding PSF</td>
<td>(675)</td>
<td>(2,054)</td>
<td>(1,379)</td>
</tr>
<tr>
<td>Control total excluding PSF</td>
<td>(722)</td>
<td>(722)</td>
<td>0</td>
</tr>
<tr>
<td>Performance against control total excluding PSF</td>
<td>47</td>
<td>(1,332)</td>
<td>(1,379)</td>
</tr>
</tbody>
</table>

Further to the discussions in December and subsequently the Trust is forecasting to NHSI a net deficit against our plan of £2m. The Trust 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. The Trust have subsequently met with the Director of Finance for NHS Improvement London and stated its case for changing its forecast outturn and not hitting its original control total. This position has been submitted to NHSI in line with its formal processes.

In previous Months the Trust has indicated that the risk to the forecast was circa £7m. The position reported in Month 10 represents a £5m improvement on that stated risk. This improvement has been achieved by:

- Securing additional funding from CCGs to support the Flow Plan.
- Increasing assurance around the disposal of properties and an increase on expected profit on disposal.
- Positive expected movement in the Trust’s underlying expenditure.
- Additional identified flexibility following a review of the 2019/20 control total and planning requirements

The Board is asked to approve the report including consideration of the pressures, risks and mitigations in place to meet the revised forecast total and the associated risks and mitigations detailed below.
Executive Summary

The attached return shows an adverse YTD position of £2m and an adverse FOT variance of £2m.

In addition to the risks and mitigations detailed in the narrative explicit consideration should be given to a number of key assumptions underpinning the reported position:

- Overspill remains at an average of 61 private sector beds until year end
- Rye Lane and Ann Moss property disposals are completed before 31st March 2019
- There are no further reductions in Q4 income not already notified to the Trust
- Southwark Placements income is recovered and risk agreements honoured
- NHS England honour their contractual obligations around New Models of Care and CAMHS PICU services.
- CCG’s are able to provide the additional support offered to the Trust to support the flow plan in 2018/19.

Formal In-Year Financial Forecast Change

In line with the formal protocols specified by NHS Improvement the Trust has taken a number of steps to ensure that the forecast change made is considered and robust. These formal changes have been made following informal discussions with the NHSI London DoF in December and January.

Relevant commissioners have been informed of the position and all opportunities for support have been explored and the recovery actions agreed.

- SLaM has been reporting financial risks in its reporting since Month 5 (August) which has been discussed with and made available to the Trust’s commissioners and regulators.
- SLaM has contacted all of its key commissioners to seek additional support around inpatient pressure and funding the flow plan.
- Commissioners are aware of the actions taken around managing inpatient capacity and the flow plan and this has been supported by NHSI at the Regional Oversight Group.

The senior clinical decision-making body with the provider has been engaged with and are party to the identification and delivery of the recovery actions.

- The development of the flow plan has involved the Trust’s clinical directors and other senior clinicians.
- The Flow plan is monitored at weekly meetings attended by senior clinicians.
- The Flow plan has been agreed by the Trust board and reviewed by the Quality committee.

NHS trust / foundation trust Executive Committee, Finance Committee and Board have considered and agree the proposed financial forecast revision and recovery actions.

- SLaM has been reporting financial risks in its reporting since Month 5 (August) which has been reported to and discussed with the Trust executive committee (SMT), Finance Committee (FPC) and ultimately the Trust Board.
- The above committees have all agreed to the position reported and associated recovery / action plans and mitigations.
- Further work to be done on reducing the forecasted overspill position (current forecast based on an average of 61 overspill beds).
- Discussions with Commissioners around recovery of additional income to fund the flow plan.

Additional Measures and Mitigations

The financial performance of the Trust is reviewed as part of the weekly SMT executive team meeting and as part of a monthly finance portfolio board chaired by the CEO. In addition, All directorates are
subject to a monthly Quality, Performance and Finance review. This includes reviewing the position and setting corresponding actions plans which includes:

- capital/cash management (the Trust’s cash position remains robust), including capital programme review (which is considered in detail at a monthly capital review group).
- Reviews of all discretionary spend, agency/locum spend, supplies and consumable spend and delegated commitment range and levels.
- The affordability of planned investments to improve service quality and performance. The most notable would be the weekly flow plan meeting which reviews the impact and cost of the agreed plan.
- The acceleration of proposals for sub-scale service consolidation or closure;
- The impact on patient safety and experience of recovery actions;
- Impact and financial recovery trajectories.

**Forecast Risk Financial Bridge**

The following bridge table summarises the risk assessed forecast position that is being reviewed by the Trust Board and NHSI (i.e. the £6.9m gap). This would mean that the Trust would deliver a £4.5m deficit against a plan of £2.5m surplus (including PSF funding).

However, additional mitigation has been secured through a combination of CCG support, additional disposal gains, expected run rate improvement and other non recurrent means. This would close the gap to £2m which NHSI have intimated would be less likely to lead to formal intervention based on the known pressures.

Delivery of this position remains dependant on NHSE paying their full NMoC contract, CCGs providing additional support for the Flow Plan and securing the Sale of Ann Moss and Rye Lane before 31st March (as expected).
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 £6.3m based on a YTD run rate of 61 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 £0.4m unfunded cost in 2018/19.

   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:

- Overspill does not go above the forecasted average of 61 beds.
- The disposals of Ann Moss and Rye Lane properties are completed before 31 March 2019.
- That there are no further unknown reductions of forecasted Q4 income.
- CCG risk share agreements are honoured.
- 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).
- CQUIN is fully funded and there is no penalty to SLaM for unmet QIPP.

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

**Risks / issues for escalation**

<table>
<thead>
<tr>
<th>BAF Risk 1 - Workforce</th>
</tr>
</thead>
<tbody>
<tr>
<td>BAF Risk 8 – Finance - contracts</td>
</tr>
<tr>
<td>BAF Risk 9 – Estates</td>
</tr>
<tr>
<td>BAF Risk 11 – QI delivery</td>
</tr>
<tr>
<td>BAF Risk 12 Finance – cost management</td>
</tr>
</tbody>
</table>

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

- **Acute/PICU Overspill**

Overall 51 overspill beds were used by the Trust in January, 48 beds above our original plan. The use of overspill and other non local CCG beds has resulted in a cost pressure, after application of risk shares, of £4.7m after 10 months. The Trust response to this is picked up in the Performance Report.

The main drivers of this contract over performance and hence resort to using beds outside the Trust continue to be Lambeth (ytd - 21% above contract), Southwark (ytd - 14% above contract) and Lewisham (ytd - 18% above contract). Lewisham in particular is experiencing unprecedented levels of contract overperformance as seen in the graph below:
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 over performance 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>%</th>
<th>Last Mth Beds</th>
<th>Risk Share Value £000</th>
</tr>
</thead>
<tbody>
<tr>
<td>Lambeth</td>
<td>82</td>
<td>99</td>
<td>17</td>
<td>21.2%</td>
<td>17</td>
<td>1,512</td>
</tr>
<tr>
<td>Southwark</td>
<td>76</td>
<td>87</td>
<td>11</td>
<td>14.0%</td>
<td>12</td>
<td>684</td>
</tr>
<tr>
<td>Lewisham</td>
<td>65</td>
<td>77</td>
<td>12</td>
<td>18.4%</td>
<td>12</td>
<td>657</td>
</tr>
<tr>
<td>Croydon</td>
<td>82</td>
<td>85</td>
<td>3</td>
<td>3.1%</td>
<td>2</td>
<td>189</td>
</tr>
<tr>
<td>NCA/Overseas</td>
<td>21</td>
<td>17</td>
<td>-4</td>
<td>-19.5%</td>
<td>-4</td>
<td>0</td>
</tr>
<tr>
<td>Total</td>
<td>326</td>
<td>365</td>
<td>38</td>
<td>11.8%</td>
<td>39</td>
<td>3,042</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 £3.4m above that ceiling at month 10 and at present rates of expenditure will be £4.4m 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 10 ytd the Trust had incurred an additional expense of £2.7m 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 £000</th>
<th>Agency Usage £000</th>
<th>Agency Usage %</th>
<th>Estimated Cost Above Funding £000</th>
</tr>
</thead>
<tbody>
<tr>
<td>Lambeth</td>
<td>26,201</td>
<td>2,330</td>
<td>9%</td>
<td>388</td>
</tr>
<tr>
<td>Southwark</td>
<td>31,556</td>
<td>2,022</td>
<td>6%</td>
<td>337</td>
</tr>
<tr>
<td>Lewisham</td>
<td>22,680</td>
<td>2,143</td>
<td>9%</td>
<td>357</td>
</tr>
</tbody>
</table>
### Ward/Unit Nursing Costs

In month 10 ward nursing costs overspent by £417k (£2.2m ytd overspend). 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 82% of the total ward/unit nurse overspend. Included within this are Lambeth Challenging Behaviour Unit, Johnson Unit PICU and Clare (Lewisham) and Fitzmary 1 (Croydon) which are all +15% above their funded nurse establishments.

<table>
<thead>
<tr>
<th></th>
<th>Costs</th>
<th>Vol</th>
<th>%</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Croydon</td>
<td>46,118</td>
<td>4,418</td>
<td>10%</td>
<td>736</td>
</tr>
<tr>
<td>PMOA</td>
<td>29,930</td>
<td>845</td>
<td>3%</td>
<td>141</td>
</tr>
<tr>
<td>CAMHS</td>
<td>30,749</td>
<td>2,055</td>
<td>7%</td>
<td>343</td>
</tr>
<tr>
<td>Other</td>
<td>50,783</td>
<td>2,499</td>
<td>5%</td>
<td>417</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>238,019</strong></td>
<td><strong>16,313</strong></td>
<td><strong>7%</strong></td>
<td><strong>2,719</strong></td>
</tr>
</tbody>
</table>

### 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** – income below target on Psychosis Unit (currently 51% occupancy following agreed bed closures) and NAU (reduction in beds/income due to continuing building works).
- **PMOA** – part of this year’s CIP programme was to retain the 17/18 income targets but make progress towards meeting them. This is yet to occur uniformly with some of those services that underperformed last year - in particular, neuropsychiatry outpatients, eating disorders, chronic fatigue and affective disorders are not currently meeting activity targets.
- **CAMHS** – partially 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. However there are also income shortfalls on inpatient services (£0.6m) where activity remains below target in Kent and on Snowsfields 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 now fully open 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.)
Some of these shortfalls (45% 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 9 the LA element of placements has cost £1.9m with £1.5m costs classed as unallocated, 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 £1.3m. This situation is being taken up with the Council/CCG and whilst progress is being made, the funding gap still exists. The Council are disputing the split of costs between themselves and the CCG, both parties are currently working to try and resolve this issue.

2. **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.

3. **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>1,608</td>
<td>-224</td>
<td>-1,832</td>
<td>2,403</td>
<td>0</td>
<td>-2,403</td>
<td>Overspill remains High Risk due to ongoing bed pressures in SE London</td>
</tr>
<tr>
<td>Direct engagement of staff</td>
<td>High</td>
<td>56</td>
<td>0</td>
<td>-56</td>
<td>80</td>
<td>0</td>
<td>-80</td>
<td>Scheme delayed</td>
</tr>
<tr>
<td>Estates Reduction 1</td>
<td>High</td>
<td>120</td>
<td>284</td>
<td>164</td>
<td>358</td>
<td>358</td>
<td>0</td>
<td>This is still expected to deliver but pressure on estates due to CQC related programmes means this remains a high risk.</td>
</tr>
<tr>
<td>Lambeth &amp; Lew PICUs</td>
<td>High</td>
<td>74</td>
<td>12</td>
<td>-62</td>
<td>156</td>
<td>24</td>
<td>-132</td>
<td>This remains high risk due to demand pressures on beds</td>
</tr>
<tr>
<td>Borough Restructure Target - 2nd Tranche</td>
<td>High</td>
<td>100</td>
<td>100</td>
<td>0</td>
<td>300</td>
<td>300</td>
<td>0</td>
<td>Savings have been identified but on hold following focus on CQC issues and inpatient pressures</td>
</tr>
<tr>
<td>SLP Collaboration</td>
<td>High</td>
<td>166</td>
<td>167</td>
<td>1</td>
<td>500</td>
<td>500</td>
<td>0</td>
<td>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>
</tr>
<tr>
<td>Promoting Recovery Teams</td>
<td>High</td>
<td>162</td>
<td>162</td>
<td>0</td>
<td>486</td>
<td>486</td>
<td>0</td>
<td>Was expected to deliver but will remain high risk until Borough reconfigurations are finalised</td>
</tr>
<tr>
<td>CPC Outpatients income</td>
<td>High</td>
<td>128</td>
<td>33</td>
<td>-95</td>
<td>201</td>
<td>97</td>
<td>-104</td>
<td>Activity driven – remains high risk</td>
</tr>
<tr>
<td>CAMHS Inpatient income</td>
<td>High</td>
<td>128</td>
<td>0</td>
<td>-128</td>
<td>191</td>
<td>0</td>
<td>-191</td>
<td>Delay in converting beds to HDU</td>
</tr>
<tr>
<td>CAMHS Southwark Estates savings tied into service redesign</td>
<td>High</td>
<td>48</td>
<td>0</td>
<td>-48</td>
<td>76</td>
<td>0</td>
<td>-76</td>
<td>This relates to the exit of a Trust site that is off track - alternative schemes are being identified</td>
</tr>
<tr>
<td>Nursing Management Unidentified CIP 18/19</td>
<td>High</td>
<td>24</td>
<td>3</td>
<td>-21</td>
<td>38</td>
<td>17</td>
<td>-21</td>
<td>Nursing management budgets are underspending but this CIP is yet to be finalised.</td>
</tr>
<tr>
<td>Site Manager Post redundant</td>
<td>High</td>
<td>48</td>
<td>0</td>
<td>-48</td>
<td>68</td>
<td>0</td>
<td>-68</td>
<td>Post removed but non rec redundancy payment offsetting saving</td>
</tr>
<tr>
<td>Agency Spend</td>
<td>High</td>
<td>280</td>
<td>0</td>
<td>-280</td>
<td>500</td>
<td>300</td>
<td>-200</td>
<td>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>
</tr>
<tr>
<td><strong>Total</strong></td>
<td></td>
<td>2,942</td>
<td>537</td>
<td>-2,405</td>
<td>5,357</td>
<td>2,082</td>
<td>-3,275</td>
<td></td>
</tr>
</tbody>
</table>

4. **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)

5. **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.
6. Balance Sheet

- No issues of note at this point in the year other than timing.
- Capex YTD M10 is £11.8m behind plan due to slippage including:
  - £1.8m CAMHS LD
  - £1.6m New Build NAU
  - £1.5m Digital projects
  - £1.5m Gresham & Fitzmary Windows
  - £1.3m other ward refurbishment
  - £1.1m New build CYP
  - £0.8m Gracefield Gardens refurb
  - £0.8m AL3 Ward Refurbishment
  - £0.7m Lambeth windows
  - £0.5m Norbury Ward
  - £0.5m CTI
  - £0.5m Estates Backlog maintenance schemes
  - £0.3m Maudsley outpatients refurb

7. Revenue Support Drawdown

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

8. Schedule of risks and opportunities against FOT

- Acute overspill averaged 51 beds in the month – a decrease on December (58). This number excludes local CCG patients over spilling into Trust beds that were planned to be funded by NCA activity (non contracted activity – primarily overseas and cross boundary flow patients). The net financial impact of overspill and loss of NCA income is £4.7m 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 21% above contract, Lewisham 18% over contract, Southwark 14% 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 £3.7m. 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 10 months is £3.4m 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 £2.3m higher than at this point last year and on current run rates will exceed the new ceiling by £4.4m 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 disproportionally high (a third of total agency costs) with overall agency usage highest in the adult boroughs at 10% 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. Corresponding pay underspends will mitigate 45% of this variance but a number of services are required to improve their performance over the remaining 3 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, the unfunded amount has further decreased to £0.4m. 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 £0.4m cost pressure will need to be taken account of in our forecast position.

9. 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.
| **AMH** | 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 |
| **CCG** | Clinical Commissioning Group – an NHS body responsible for the planning and commissioning of health services for their local area |
| **CIPs** | Cost Improvement Programme |
| **CPC/C&V** | Cost per Case and Cost and Volume income varies depending upon the amount of clinical activity being undertaken |
| **EBITDA** | Earnings before interest, tax, depreciation and amortisation is an accounting measure used as a proxy for an organisation's current operating profitability |
| **ICT** | Information and Communications Technology |
| **NCA** | 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) |
| **NHSI** | NHS Improvement – the new regulatory body overseeing all NHS providers as well as independent providers that provide NHS funded care |
| **OBD** | 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) |
| **O/P** | Outpatient |
| **PICU** | 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 |
| **PoS** | Place of Safety – under section 136 of the Mental Health Act, the police have the power to take an apparently mentally disordered person who is in a public place and is apparently a danger to himself or to other people, to a “place of safety” where they may be assessed by a doctor |
| **QIPP** | 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 |
| **STF** | Sustainability & Transformation Fund that is intended to support providers to move to a sustainable financial footing |
| **STP** | 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. |
| **Triage** | 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 |
| **WTE** | 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 |
| **YTD** | Year To Date |
1) At Month 10 ytd the Trust had a deficit of £1m, a deficit variance of £2m against the NHSI surplus control total.

2) Adult overspill averaged 51 beds in the month—a decrease from an average of 58 beds in M9. 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). The net financial impact of overspill and loss of NCA income is £6.7m 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 Ptd positions of CCGs against contract are Lambeth 21%, Lewisham 18%, Southwest 14%, Croydon 3%.

3) Ward nursing costs remain high particularly in the Lambeth, Lewisham and Croydon adult wards which represent 85% of the total. Although budgets are set at safer staffing levels, some wards are not able to keep within these establishment. The position is being compounded by the Agenda For Change (AFC) pay award where our nurse bank staff are paid on an incremental point that attracts a higher level of pay award than other staff on the same band but at a different incremental point. This fact has not been recognised in the pay award uplift from the Department of Health.

4) As at month 10, the Trust had generated CIP savings of £1m. The current adverse variance from the CIP plan of £2.3m is largely driven by our failure to meet acute overspill targets as indicated above. Further risks are likely to emerge in Q4 if NHSI fail to meet the requirements of agreed performance plans of Care business cases and proposed efficiencies from the foundation trust. The Trust is largely meeting its CCG DFF targets although it is not keeping to its baseline acute obd positions.

5) Complex placements are reporting a balanced position. However there remains a key risk in Southwark where the Local Authority is no longer in 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 10 months is £2.3m 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 £2.3m higher than at this point last year and on current run rates will exceed the new ceiling by £4.6m at year end. Medical agency costs are disproportionately high and agency usage is highest in the adult hospitals.

7) Last year the Trust, overall, met its cost and volume income targets (higher risk income that relates directly to increases/decreases in activity). However over the overall performance resilient 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 (65% of which will be offset by associated net pay underspends).

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 cost. We have estimated a shortfall of £400k.

9) As at M10 ytd the Trust is 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 finance performance of the Trust only. We are forecasted for our score to worsen in a 3.
## The South London and Maudsley NHS Foundation Trust - Operating Budgets

### Table 1

#### January 2019

<table>
<thead>
<tr>
<th>Service Analysis</th>
<th>Full Year Live Budgets (£)</th>
<th>Monthly Figures</th>
<th>Year to Date Figures</th>
<th>As At Mth 10</th>
<th>Change</th>
<th>As At Mth 8</th>
<th>Notes Re Mth 10</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Current Actual(£)</td>
<td>Variance From Live(£)</td>
<td>Variance Last Month (C)</td>
<td>Forecast Variance (C)</td>
<td>Movement From Previous Forecast (C)</td>
<td>Forecast Variance (C)</td>
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<td>25,244,920</td>
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<td>6,700,500</td>
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<td>4,555,700</td>
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<td>1V. Strategy &amp; Business Development</td>
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<td>63,400</td>
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<td>567,400</td>
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<td>1VI. Chief Executive</td>
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<td>8,136,700</td>
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<td>1VII. Medical &amp; Clinical Governance</td>
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<td>11,376,900</td>
<td>694,400</td>
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<td>1VIII. Chief Operating Officer</td>
<td>7,569,500</td>
<td>1,755,300</td>
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<td>6,405,000</td>
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<td>1IX. South London MI Partnership</td>
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<td>1X. R&amp;D</td>
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<td>816,000</td>
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<td>4,116,000</td>
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<td>1XI. Infrastructure &amp; Facilities</td>
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<td>83,382,300</td>
<td>3,930,500</td>
<td>3,630,300</td>
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</tbody>
</table>

### Forecast

- **Notes Re Mth 10**
  - High capital planning agency costs above budget and car park income delayed.
  - Unmet CIPs.
  - High legal fees in relation to major legal cases.
  - Costs associated with developing new car parking facilities.
  - Cost of junior doctors above budget including use of locums and unmet CIPs.
  - Cost of unmet CIPs.
  - £0.5m reduction in RCF funding.

- **Corporation Other**
  - Includes non rec transfer of Q1 lock ins (£2.1m) to reserves.

- **EBITDA**
  - Includes various cost pressures in Estates (main teams), hotel service, PR (earning income, cost of payroll transfer & apprenticeship schemes), Medical (junior doctors), Nursing (legal fees - inquests) & R&D (0.5m reduction in RCF funding).

- **Trust Financial Position**
  - Includes £2.1m transfer to reserves.

- **Forecasts**
  - GBP.

- **Notes**
  - Trust financial performance.

### Other reserves/provisions

- **Monthly Figures**
  - Year to Date Figures

### Table 1

#### As At Mth 10

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#### Forecasts

- GBP.

#### Notes

- Trust financial performance.
Table 2
NHSI Summary For South London & Maudsley NHS Foundation Trust

<table>
<thead>
<tr>
<th>Key data</th>
<th>Plan 31/01/2019</th>
<th>Actual 31/01/2019</th>
<th>Variance</th>
<th>Plan 31/03/2019</th>
<th>Forecast 31/03/2019</th>
<th>Variance</th>
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</thead>
<tbody>
<tr>
<td></td>
<td>YTD £'000</td>
<td>YTD £'000</td>
<td>YTD £'000</td>
<td>YTD £'000</td>
<td>YTD £'000</td>
<td>YTD £'000</td>
</tr>
<tr>
<td>Performance against control total</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Surplus/(deficit) before impairments and transfers</td>
<td>931 (1,039)</td>
<td>1,978 (515)</td>
<td>(2,482)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Adjusted financial performance surplus/(deficit) including PSF</td>
<td>1,371 (599)</td>
<td>2,506 (13)</td>
<td>(2,483)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Control total</td>
<td>1,331</td>
<td>1,331</td>
<td>0</td>
<td>2,459</td>
<td>2,459</td>
<td>0</td>
</tr>
<tr>
<td>Performance against control total excluding PSF</td>
<td>40 (1,339)</td>
<td>47</td>
<td>(2,446)</td>
<td></td>
<td></td>
<td>(2,493)</td>
</tr>
<tr>
<td>Surplus/(deficit) before impairments and transfers</td>
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<td>2,506 (13)</td>
<td>(2,493)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Adjusted financial performance surplus/(deficit) excluding PSF</td>
<td>1,161 (1,107)</td>
<td>(752)</td>
<td>(735)</td>
<td></td>
<td></td>
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<tr>
<td>Adjusted financial performance as a % of Turnover (I&amp;E Margin)</td>
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<td></td>
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<tr>
<td>Including PSF</td>
<td>0.43% (0.18%)</td>
<td>0.65% (0.00%)</td>
<td>(0.65%)</td>
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<tr>
<td>Excluding PSF</td>
<td>(0.34%) (0.81%)</td>
<td>(0.18%) (0.52%)</td>
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<td>EBITDA as a percentage of related income</td>
<td>2.88% (0.89%)</td>
<td>3.14% (1.42%)</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Performance against control total</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
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<td></td>
<td></td>
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<tr>
<td>Adjusted financial performance surplus/(deficit) excluding PSF</td>
<td>1,161 (1,107)</td>
<td>(752)</td>
<td>(735)</td>
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<td>EBITDA value</td>
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<td>as a percentage of related income</td>
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<td>3.14% (1.42%)</td>
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<tr>
<td>Efficiencies</td>
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<td>Total recurrent efficiencies</td>
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<td>15,020</td>
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<td>(3,090)</td>
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<td>(3,110)</td>
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<td>13,998</td>
<td>(2,403)</td>
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<tr>
<td>Total efficiencies</td>
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<td>16,401</td>
<td>13,998</td>
<td>(2,403)</td>
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<td>Total efficiencies as a percentage of expenditure (before efficiencies)</td>
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<td>11,735</td>
<td>16,556</td>
<td>2,397</td>
<td>14,159</td>
</tr>
<tr>
<td>Less donations and grants received</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Less PFI capital (IFRIC12)</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Plus PFI residual interest</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Other including additions to financial assets / prior period adjustments</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Total CDEL</td>
<td>11,685</td>
<td>(50)</td>
<td>11,735</td>
<td>16,556</td>
<td>2,397</td>
<td>14,159</td>
</tr>
<tr>
<td>Cash</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Cash and cash equivalents at period end</td>
<td>65,884</td>
<td>71,285</td>
<td>5,401</td>
<td>64,372</td>
<td>72,963</td>
<td>8,591</td>
</tr>
<tr>
<td>DHSC capital financing</td>
<td>2,928</td>
<td>573</td>
<td>(2,355)</td>
<td>4,393</td>
<td>1,313</td>
<td>(3,080)</td>
</tr>
<tr>
<td>DHSC interim revenue financing</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Agency and contract</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Total agency costs excluding outsourced bank</td>
<td>12,869</td>
<td>16,314</td>
<td>(3,445)</td>
<td>15,124</td>
<td>19,576</td>
<td>(4,452)</td>
</tr>
<tr>
<td>Updated agency ceiling</td>
<td>12,869</td>
<td>12,869</td>
<td>0</td>
<td>15,125</td>
<td>15,125</td>
<td>0</td>
</tr>
<tr>
<td>Agency costs as a percentage of gross payroll costs</td>
<td>5.46% (6.66%)</td>
<td>5.36% (6.86%)</td>
<td>1.40%</td>
<td>5.36%</td>
<td>6.86%</td>
<td>1.47%</td>
</tr>
<tr>
<td>Turnover</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Total operating income</td>
<td>320,188</td>
<td>329,556</td>
<td>9,368</td>
<td>348,461</td>
<td>395,530</td>
<td>11,049</td>
</tr>
<tr>
<td>Less capital donations/grants income impact</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Remove impact of prior year PSF post accounts reallocation</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Total turnover</td>
<td>320,188</td>
<td>329,556</td>
<td>9,368</td>
<td>348,461</td>
<td>395,530</td>
<td>11,049</td>
</tr>
</tbody>
</table>

Use of resources risk rating summary

<table>
<thead>
<tr>
<th>Plan 31/12/2018</th>
<th>Actual 31/12/2018</th>
<th>Variance</th>
<th>Plan 31/03/2019</th>
<th>Forecast 31/03/2019</th>
<th>Variance</th>
</tr>
</thead>
<tbody>
<tr>
<td>YTD Number</td>
<td>YTD Number</td>
<td>YTD</td>
<td>YTD Number</td>
<td>YTD Number</td>
<td>YTD</td>
</tr>
<tr>
<td>Capital service cover rating</td>
<td>3</td>
<td>3</td>
<td>2</td>
<td>4</td>
<td></td>
</tr>
<tr>
<td>Liquidity rating</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td></td>
</tr>
<tr>
<td>I&amp;E margin rating</td>
<td>2</td>
<td>3</td>
<td>2</td>
<td>2</td>
<td></td>
</tr>
<tr>
<td>I&amp;E margin: distance from financial plan</td>
<td>2</td>
<td>2</td>
<td>2</td>
<td>2</td>
<td></td>
</tr>
<tr>
<td>Updated agency rating</td>
<td>1</td>
<td>3</td>
<td>1</td>
<td>3</td>
<td></td>
</tr>
<tr>
<td>Risk rating after overrides</td>
<td>2</td>
<td>2</td>
<td>2</td>
<td>2</td>
<td></td>
</tr>
</tbody>
</table>
### Table 3 Summary CIP Performance

<table>
<thead>
<tr>
<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>Pay</td>
<td>8,726</td>
<td>8,908</td>
<td>182</td>
</tr>
<tr>
<td>Non Pay</td>
<td>6,428</td>
<td>3,949</td>
<td>(2,479)</td>
</tr>
<tr>
<td>Income</td>
<td>1,247</td>
<td>1,140</td>
<td>(107)</td>
</tr>
<tr>
<td>Recurrent</td>
<td>15,021</td>
<td>12,031</td>
<td>(2,990)</td>
</tr>
<tr>
<td>Non Recurrent</td>
<td>1,380</td>
<td>1,966</td>
<td>586</td>
</tr>
</tbody>
</table>

#### Summary of Progress

The position at Month 9 is £208k behind the in month target of £1.8m and £2.3m behind the YTD target of £11.1m.

The primary driver behind the YTD position is acute overspill which accounts for £2m YTD underachievement and agency.

The full year forecast is expected to deliver £14m which is £2.4m behind the plan of £16.4 m, mainly due to the deterioration of overspill. The forecast includes non recurrent values of £2.1m in relation to lock ins.

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

- **a)** within the forecast there is £1.8m of schemes which are Red Rated - this includes savings relating to the restructure, Estates, SLP collaboration.
- **b)** Notable areas where there are potential risks to the projected forecast includes:
  - LEWISHAM - Lewisham Triage and PICU (£123k) / LAMBETH - PICU and CPC - Self Harm (£39k) / PMDA - CPC schemes (£38k)
  - Additionally there is some uncertainty around the Patient Wide Pathways scheme (£218k) which is split across all Boroughs and has a significant degree of risk until the devolvement of posts is finalised.

**The key movements underlying the in month variance are:**

**Overspill on beds**

- CAMHS - N&S Inpatient SDS Income (£191k) and Southwark Estates (£76k)
- LAMBETH - OASIS (£110k) not expected to deliver
- Trustwide - The lock in position is expected to be more favourable than planned (£586k), however partially offset by an adverse position in agency (£300k)

**Corporate Services:**

- Medical - Ahead of target on training review
- Nursing & Clinical Governance - Slightly ahead of target on staffing reviews in Health and Safety and Chaplaincy
- HR - Direct Engagement scheme not expected to deliver
Title | CHIEF EXECUTIVE’S REPORT  
---|---
Author | Dr Matthew Patrick

**Purpose of the paper**

To inform the Board about significant issues affecting the Trust.

**A – Trust Leadership Team**

The Trust Leadership Team consists of our Service Directors, Clinical Directors, Heads of Profession, Corporate Directors, Heads of Nursing and Medical Leads. We meet on a monthly to discuss strategic issues, share information and set the leadership direction for the Trust.

On the 30th January, we met up for an Away Day at Prospero House in Borough. We explored a range of important issues, including the changing NHS landscape and what it means for us as a Trust, and our priorities for the coming 9 – 12 months.

It was a constructive and high-energy day and we have now agreed the steps that need to be taken to turn our discussions into action. These range from large-scale actions such as Quality Improvement projects to improve staff engagement and joy at work, to early wins such as improving staff areas and changing the name of the Senior Management Team to the Executive Leadership Team, and much more.

**B – South London Partnership Board**

There was a full agenda at the South London Partnership Board the 31st January, reflecting the considerable partnership activity going on across the three partner trusts.

A particular highlight this month was the excellent news that the average distance from home for our Tier IV CAMHS service users is now 7 miles, down from 73 miles when the work was started. This will make a significant difference to the lives of the young people who use these services as well as their families and friends.
Other items for discussion included the business case for a new Clinical Decision Unit for our secure forensic services and a brand new adult care pathway programme. At the next meeting, NHS Benchmarking will be presenting data pertaining to our adult care pathways across the South London Partnership.

C – Our International work

Together with our Director for Strategy and Commercial, I visited the United Arab Emirates during the week of 11th February. This was a welcome opportunity to hear from our Trust staff who are driving high-standards of care and quality improvement in outpatient services. Our staff are also working with local UAE staff who are working to achieve JCI (Joint Commission International) accreditation for the Al-Amal Hospital over the next few weeks. It was a pleasure to meet staff and hear about their excellent work.

D- Funding review visit

The Trust was recently selected by the National Institute for Health Research for a funding review visit. The visit took place on the 11th and 12th of February and followed the submission of detailed information about our funding procedures, particularly in relation to the Biomedical Research Centre (BRC).

Together with the R&D Directors and staff, the BRC Director and others, I joined a number of helpful visits and meetings. This included a showcase presentation and tour by the BRC Director and the three theme leads – all well received by our visitors. The informal feedback at the end of the visit was positive and we look forward to receiving the formal feedback letter.

E – Launch of the Staff Recognition Awards

Nominations are now open for the 2019 SLaM Staff Recognition Awards – a fantastic opportunity to recognise the efforts and achievements of our dedicated staff who go the extra mile to improve the lives of the people and communities we serve. We want staff, service users and carers to take this opportunity to shine a spotlight on the great work of a colleague, service or team.

This year's Staff Awards are generously supported by the Maudsley Charity, which funds a wide range of important projects across the trust. This year's event will be held at a new venue in Central London and I know that it will be a wonderful opportunity to celebrate the great work that goes on across the Trust to improve the lives of our service users.
REPORT TO THE TRUST BOARD: PUBLIC
26 February 2019

<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>
</tr>
</tbody>
</table>

**Purpose of the paper**

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

**Quality Working Group – 24 January**

The Group’s first piece of business was to ratify the appointment of Gill Sharpe, Public Governor, as its new Chair.

The rest of the meeting was devoted to looking at the evolving Performance & Quality report, with Governors considering:

- Is it clear what is being reported on, and why? Which areas are less clear and would benefit from additional explanation?
- Which performance indicators are most important to you? Are there any that you would want to see prioritised over others?

Rod Booth (Director of Contracts, Performance and Operational Assurance), Mary O'Donovan (Head of Quality) and Geraldine Strathdee (NED) joined the meeting.

**Governor / NED meeting – 29 January**

A group of Governors attended a formal meeting with the Non-Executive Directors ahead of the Board meeting on 29 January. Assurance was sought from the NEDs in respect of:

- Flow and bed stock
- Commissioning and other sources of income
- Planning for discharge
- Staff wellbeing
- BME gender pay gap

**Governor-only meeting – 31 January**

Governors meet quarterly to discuss matters arising on an informal basis. This is an opportunity to share feedback on recent community events, share views and to collate and record questions for forthcoming meetings with the NEDs, or working group meetings.
Governor / Non-Executive Director site visit – 5 February

A group of Governors and NEDs visited Nelson Ward at Lambeth Hospital on 5 February and learned more about the implementation of the Red2Green process in that setting. Governors were encouraged that staff feel that it is improving the effectiveness of ward meetings and are keen to ensure that the impact on service user experience is tracked as well as the impact on discharges. There were concerns about the estate / environment of the ward, which have been raised with the Acting Deputy Director, who has responded with the relevant action plan. The Governors thanked those who facilitated the visit, reflecting on their openness and willingness to answer questions.

A full note of the feedback from the visit will be circulated to Governors with the Council of Governors papers in March, and one of the NEDs will provide a verbal update at February’s Board.

Planning and Strategy Working Group meeting - 7 February

The meeting opened with a screening of the film developed to support the Changing Lives strategy, which the group has been tracking. This film will also be shown at the Council of Governors meeting in March.

Andy Bell (Director of Finance) and June Mulroy (NED) joined the meeting and Governors were consulted on the Trust’s draft operational plan for 2019-20 ahead of its submission to NHSI. Andy Bell took Governors through the process for financial planning for the year ahead, and June Mulroy took Governor questions on issues arising from recent Business Development & Investment Committee and Finance & Performance Committee meetings.

Membership and Involvement Working Group meeting – 12 February

The agenda for this meeting focused on the group’s identified priorities, namely increasing staff interest in becoming a Governor, and engagement with BME members. The group revisited the member engagement strategy.

Chairs’ meeting / forward planning meeting – 14 February

The Chairs of the Working Groups meet on a quarterly basis to discuss matters arising and to develop the next agenda for the Council of Governors meeting. On this occasion, it was also an opportunity for the Deputy Chairs to attend and for the forward work plans of the Working Groups to be prepared collaboratively, recognising potential areas of overlap between the groups and also opportunities for collaborative working.
Title | QUALITY COMMITTEE UPDATE
---|---
Non-Executive Director | Anna Walker, Non-Executive Director

Purpose of the paper

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

- the key issues discussed at the Committee meeting on 15 January and the actions proposed;
- the key points of assurance;
- the key risks that the Chair or the Committee wish to flag; and
- any issues to flag to other Committees.

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

Board Assurance Framework

- BAF Risk 1 Workforce
- BAF Risk 2 Operational delivery structure
- BAF Risk 3 Informatics
- BAF Risk 5 Partnership working with service users
- BAF Risk 7 Quality & statutory compliance
- BAF Risk 14 Patient flow

KEY ISSUES SUMMARY

| Actions proposed to address key issues |
| Data collection, key performance metrics and the Performance & Quality report. |

Work to develop and agree a data set for floor-to-Board Performance & Quality reports has moved on. There have been some real improvements. A meeting of NEDs and the Executive in January helped to clarify expectations and what the Quality Committee needs to see by way of data in order to add value and hold the Executive to account. It had been too late to implement some of the agreed changes to the report for this Committee meeting but they would be actioned for future Quality Committee and Board reports. It was also been agreed that, in future, the Quality Committee would have a short narrative from the executive outlining their concerns as a result of the report, the reasons for those concerns and the remedial action planned.

The Performance and Quality (P&Q) report would benefit from clearer labelling to distinguish national indicators from local ones (e.g. CCG requirements/ constitutional standards).
Owing to an oversight, narrative relating to amber-rated inpatient wards on QuESTT was not included in the P&Q report presented to the Committee and this should be rectified in future.

The Committee welcomed the inclusion of the Quality Priority targets in the report and noted that one needed to be added (increase in the number of identified carers for service users). Overall, progress was slow against targets. The reasons for this need to be explored.

### Oversight and Scrutiny Group (OSG) report

The Group reported a shift from scrutinising processes to measuring improvement and outcomes. There has been a focus on care planning, workforce, leadership and flow. The next meeting of the Group was due to look at teams where there were concerns. Experience had showed it was important to visit wards as well as review relevant data.

### Reducing restrictive practice and violence

There are pockets of improvement, but overall the data indicates that violence and restrictive practice have not yet reduced. Benchmarking data has been requested to provide context for the Trust’s performance. SLaM is average in its use of restraint but an outlier for prone restraint. We need to understand the reasons for restraint better.

### Community QuESTT

The first data set for Community QuESTT was presented to the Committee in a live demonstration via Power BI. This was welcomed but it was noted that whilst caseload and waiting time information is available via Power BI on a team-by-team basis, this had not been reflected in the papers. This is very important information to share.

### Safer Staffing / Workforce report

The Committee has requested that Safer Staffing data is included in the Performance and Quality report, ensuring a flow of information to the Board on this important issue.

The reports only cover inpatient services as there is a regulatory requirement to publish these. The Director of Nursing highlighted that most vacancies are in community teams.

It was recognised that there are a series of workforce reports to different committees. It was agreed that the Committee Chair and Mary Foulkes would discuss streamlining these.

### Lessons Learned Q2

These papers were also received by the Board in December. The intention is to move a lot of data from this report into the Performance and Quality Report, leaving the quarterly reports to focus more on the learning. The Committee Chair will discuss with the Director of Nursing how to ensure the Quality Committee has greater visibility of the recommendations from Board level reviews and assurance that these are being implemented. There was praise for the improvements in turnaround times both on complaints and serious incident investigations.

### Learning Disability Strategy

The Committee approved the implementation of the strategy. Nurse consultants in learning disabilities are due to start in February. It is noted that until the Trust can accurately identify patients with learning disabilities (thought to be c.25% of the
patient population), the outcomes of the strategy will be difficult to measure. It was agreed that, in due course, outcome measures needed to focus more on results for service users than process issues

| Service Users’ Committee and Family & Carers’ Committee | The Quality Committee welcomed the Co-Chairs of the Service Users’ Committee and the Family & Carers’ Committee, who not only contributed positively in terms of their agenda item, but to other discussions too. The Committee was encouraged by each Committee’s achievements and forward plans designed to meet the Board’s objectives of:

- Demonstrating an improvement in the number of service users and carers involved in planning their own care;
- Ensuring coproduction is embedded in all aspects of the QI development programme;
- Demonstrating the positive impact of involving people who use services and their friends, families and carers in the delivery and governance of services. |

| Mandatory training | The Committee would like to see the pace quicken on plans to focus statutory / mandatory training on essentials only. Subject experts had indicated that changes could be made |

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**Key points of assurance**

None.

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**Key risks to flag**

**Flow (BAF Risk 14)**

Concerns were expressed at the Committee that the Trust is not going to achieve its flow plan ambitions within the timescales identified. It was recognised that there were some improvements but the issues were complex and take time to sort out. Concern was expressed by Governors at incidents of lack of bed availability.

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

**Equalities and Workforce Committee**

The Quality Committee recognises that there are papers (e.g. the workforce report, the statutory training report) which are received in other fora, including the Equalities and Workforce Committee. The Quality Committee is happy to work with the new Director of Human Resources and OD to rationalise that process so as to ensure that there is no duplication of effort.
COMMITTEE REPORT TO THE TRUST BOARD: PUBLIC
26 February 2019

<table>
<thead>
<tr>
<th>Title</th>
<th>Business Development and Investment Committee Update</th>
</tr>
</thead>
<tbody>
<tr>
<td>Non-Executive Director</td>
<td>June Mulroy</td>
</tr>
</tbody>
</table>

Purpose of the paper

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

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

Board Assurance Framework

BAF Risk 1 Workforce
BAF Risk 2 Operational delivery structure
BAF Risk 5 Partnership working with service users
BAF Risk 8 Finance – contracts
BAF Risk 12 Finance – cost management

KEY ISSUES SUMMARY

Management and Governance of Commercial Activities
- Update provided on the development of a business case for SLaM to establish a wholly owned subsidiary

<table>
<thead>
<tr>
<th>Actions proposed to address key issues</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Update to be provided to the Board (26th February) setting out key risks and benefits known at this stage of the process.</td>
</tr>
</tbody>
</table>

UAE Update
- Al Amal contract working to plan
- New operational plans for clinics launched
- Due diligence being conducted on further opportunities
- It is important that the Trust takes stock of the learning from the UAE venture and develops a ‘manual’ for venturing in the future

<table>
<thead>
<tr>
<th>Actions proposed to address key issues</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Director of Strategy and Commercial to take Béatrice Butsana-Sita (NED) through re-launched operational plans for clinics</td>
</tr>
<tr>
<td>• Strategy and Commercial Directorate to develop ‘manual’ for international venturing</td>
</tr>
</tbody>
</table>

Partnership Southwark Update
- Guy’s and St Thomas’ (GSTT) want to delay

<table>
<thead>
<tr>
<th>Actions proposed to address key issues</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Chair, CEO, CFO to meet with Senior Team at GSTT</td>
</tr>
<tr>
<td>the agreement</td>
</tr>
<tr>
<td>------------------------------------------------------------------------------</td>
</tr>
<tr>
<td><strong>Memorandum Accounts</strong></td>
</tr>
<tr>
<td>• First version of commercial finances presented to agree template/process for</td>
</tr>
<tr>
<td>recording commercial finance performance</td>
</tr>
<tr>
<td>• Director of Finance and Associate Director – Commercial to arrange for next</td>
</tr>
<tr>
<td>set to be produced focusing on one or two key ventures</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Key points of assurance</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>• The team leading on the business case for a wholly owned subsidiary has</td>
<td></td>
</tr>
<tr>
<td>engaged with NHS Trusts who have carried out this work before and have a good</td>
<td></td>
</tr>
<tr>
<td>understanding of process, opportunities and key risks</td>
<td></td>
</tr>
<tr>
<td>• Management and governance arrangements for Maudsley Health – UAE working,</td>
<td></td>
</tr>
<tr>
<td>and new reporting format agreed</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Key risks to flag</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>GSTT wish to delay Partnership Southwark agreement</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Issues to be brought to the attention of other Committees</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>None</td>
<td></td>
</tr>
</tbody>
</table>
**Title**: MENTAL HEALTH LAW COMMITTEE – 6 DECEMBER 2019

**Non-Executive Director**: Dr Geraldine Strathdee, Chair, Trustwide Mental Health Law Committee

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### 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 on 6 December 2018, the improvement actions and progress, and the Board requested benchmarking information
   - the key points of assurance;
   - the key risks that the Chair and the Committee wish to flag

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

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### Board Assurance Framework

**BAF Risk 7: Quality & statutory compliance**

Failure to carry out Mental Health Act (MHA) assessments and to provide timely access to the ‘appropriate care’ required by the Act, including admission to a bed, for persons detained under the MHA leads to a risk that the legal requirements of the MHA, the CQC regulatory standards, and the MHA Code of Practice will be breached (Paragraph 14.78) and that we will not meet our human rights and equalities duties, and ensure that care is provided in the least restrictive manner.

**BAF Risk 3: Informatics**

There is a need to improve data quality, rationalise and align the current multiple MH law information data sources (15). The immediate priority is to act on the new ability to analyse MH act trend data with the demographic and clinical data in MHSDS and EJPS. This will provide both Trustwide, and local Operational Directorate floor to Board Committees with the essential governance information they need. This will provide assurance that teams are applying the Law in a way that meets legal and regulatory standards, and also, that the care of those detained is in the least restrictive manner possible, and delivers the high quality NICE fundamental standards of care known to achieve the best outcomes. Once this is in place, the Board can be provided with a robust overview of trends, risks and performance, and improvement priorities and optimal methods.

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### KEY ISSUES SUMMARY

**Slam Trends in the use of the MH ACT & Equalities:**

In Q2 (July - Sept 2017) Slam had the same level of use of the Act and trends as for the previous quarter

**Equalities Benchmarking** (Appendix A)

A Slam trainee, researched the ethnicity of detained patients between 2016- 2018. This is a unique analysis of numbers of individual people, and not just the numbers of detentions

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

**Equalities Improvement Action and Public sector equalities duty workplan alignment:**

Discussions with the Trust public sector equalities duty programme, are taking place to map the ethnicity of patients to their levels of access to Right care services in the context of the local population profiles. The report will be taken to the Equalities Sub Committee.

**Data quality improvements needed include:**

- Full Ethnicity recording to enable identification
Analysis found that people of Black ethnicity are:

- 22% more likely to be detained on a S 2
- 28% more likely to be detained on a S 3
- 120% more likely detained on a Forensic section
- 40% higher overall for any treatment section

This raises questions as to the factors, in addition to mental health needs, of those from BAME communities who are detained, e.g. social determinants, and the potential for improvement action by partners and local communities.

**Information Data Quality:** The Committee noted that the recording of ethnicity & other potentially contributing causes of detention is not at 100%

<table>
<thead>
<tr>
<th>Strengthened Floor to Board Governance:</th>
</tr>
</thead>
<tbody>
<tr>
<td>The four Borough Operational Directorate medical leads reported from their first ‘enhanced governance’ local MH Law Committees. These raised important floor to board issues, identified how useful they find it to have information presented by local borough, the need for ‘Data literacy training’, the challenges they face, and the very helpful improvement actions planned by their local SMT members and clinical teams.</td>
</tr>
</tbody>
</table>

**Datix:** The leads are concerned to ensure consistent processes for reporting of cancelled MHA community assessments, and recording and reporting of safety consequences on Datix, and to have guidance on the clinical care, safeguarding and risk management in cancelled assessments.

**Legal standards compliance:**

- **Delayed S 2 / S3 community Mental Health Act Assessments and admissions**

When GPs, community teams or carers consider that a person has become mentally unwell and may be a risk to themselves or others and in need of hospital treatment they request assessment under S 2 / S 3 of the MH Act. Cancelled assessments, or where assessments are made and recommend admission, but there is a delay in bed availability, can put patients and the public at risk, and impact safeguarding. This has been of growing concern nationally as per Coroner’s report: [https://www.inquest.org.uk/david-stacey-opens](https://www.inquest.org.uk/david-stacey-opens)

In Q2, the highest reasons for cancelled S 2 assessments (n=75) were:

- 28(37%) No bed available
- 22 (29%) the patient was not at home
- 25 (33%) police unavailable to attend.

**Data quality: Incident recording of cancelled/delayed assessments:** Given the seriousness of the potential risks and safeguarding issues, it is important that there is full recording of incidents and that

<table>
<thead>
<tr>
<th>Strengthened Board to floor Governance:</th>
</tr>
</thead>
<tbody>
<tr>
<td>The newly established Operational Directorates Mental Health Law Committees ensure local services are sighted on the standards and can put in place responsive action to deliver, with partners, the necessary improvements.</td>
</tr>
</tbody>
</table>

**The improvement plans are**

- **Information for local SMTs:** the local leads & SMTs and clinical teams will advise on what they would value
- **Data literacy training** being considered
- The local leads will identify what practice actions they can do locally & which they consider are best done at trust wide level
- The Trustwide Committee will lead improvements that are most efficiently developed, delivered or progressed at Trust wide level

**Improvement methods to reduce cancelled community assessments which put patients and the public at risk & which have been the subject of national concern from Coroners:**

- In Southwark cancelled assessments are reviewed in the weekly safety **huddles.** Other boroughs are adopting this practice.
- The Trust’s bed **Flow improvement programme** is addressing the need for priority access to beds for detained community and ED patients
- **MADE multi agency partnership** improvement events are in place in all boroughs & have led to very helpful problem-solving with police, ambulance, section assessment and response times improvements.

**Datix Incident recording improvement**

- The Director of Nursing agreed to escalate to the Senior Management Team (SMT) the need to review the guidance and Datix definitions for recording legal breaches that lead to safety risks incidents and provide clarity as to responsibility for reporting of these incidents.
appropriate clinical risk management is put in place. It was acknowledged that (a) there are differences in the recording methods across the Borough Operational Directorates and (b) the data does not include those assessments which are not booked within a reasonable timeframe due to lack of availability of other agencies.
c) the clinical risk assessment and risk management processes are mainly recorded on eJPS and not Datix

2. **S 136 24-hour legal standard assessment**

*Section 136 numbers* have increased each year for the past 4 years. SLAM & CNWL have the largest volume in London. The cause is not fully understood & may include data quality among MHTs, reporting of ED S136s, and MHSDS data quality issues.

Of the 464 SLaM Q2 S136/135 assessments:
- 107 (23%) were beyond the statutory 24 hours.
- Of these 72 (67%) were subsequently admitted under section 2, 9 (8%) admitted under section 3, 5 (5%) informally admitted and 16 (16%) discharged.

The reasons for the over 24-hour assessments were:
- Assessment response times by medical/AMHP
- Lack of access to beds

**Patients Absent without Leave (AWOL)**

*This is an important safety issue as suicide is more common in patients that go AWOL*

SLaM reported 164 AWOLs on the Datix system in Q2
- 23 (14%) where the patient absented themselves from the ward or garden;
- 58 (35%) where the patient went AWOL while on escorted leave and
- 85 (50%) where the patient did not return at the required time when on unescorted section 17 leave.

Since April 2018 there is a reduction in AWOLs of approx. 35% X% achieved by prioritising units with greatest numbers including Gresham at Bethlem

**Benchmarking:** the pan London S 136 and AWOL report shows Slam as having the highest number of AWOLs across the London Trusts (Appendix A) but the CQC Insight Jan 2019 report shows no SLaM AWOLs

**CQC fundamental standards of clinical care**

The CQC has specific MHA monitoring arrangements and the well led inspections. In five visits in Q2, the MHA Reviewers met 20 detained patients in private, and viewed 19 clinical eJPS records. They found:

% detentions on Slam wards: On the wards inspected, a Business Intelligence snapshot on 7

**Improvement Action:**

**S 136 Improvement in assessment times: Slam Best practice**

Slam is reported by the Pan-London CEO benchmarking (Jan 2019 report) as having made the greatest improvement in assessment times (see Appendix A Benchmarking report)

NHSE (London also reports that SLaM is excellent in enabling transfers of local population residents back to SLaM, when they have presented elsewhere in London

**Improvement Action:**

- AWOLs data will be provided to each local MH Law Committees for their targeted improvement action. The Trust wide Committee will receive quarterly progress reports and requests for any action best undertaken at trust wide level

The Improvement actions include:
- Improvement in Datix recording
- Identification of units with the highest AWOLs for targeted improvement support e.g. higher perimeter fences, observations, clearer guidance on S17 leave and improved supervision on escorted leave
- **Data Quality deep dive** will be undertaken to resolve the inconsistencies between BI, CQC Insight, Pan London and our HBPOS S 136 deep dive reports on S 136/AWOLs

**S 132 Information to patients’ improvement**
January 2019 shows that the percentage of patients detained is:
- Clare Ward 85%, Johnson 90%,
- Powell 80%, Westways 76.5% & Chaffinch 100%.

(Benchmarking: NHSB National average for % of inpatients detained is 37%, higher in London Trusts)

Consistently cited breaches of fundamental clinical standards of care are:
(a) standards of capacity and consent assessments & and detailed recording on EJPS
(b) giving patients information under section 132 both when first detained and subsequent repeats,
(c) involvement of service users in their own co-produced care plans.

Other issues identified at the five visits included:
- an error with management of a Deprivation of Liberty (DOLS) application,
- lack of occupational therapy on a ward,
- an error in completion of MHA documentation,
- delay in contacting an Approved MH Practitioner

CQC Insight Nov. 2018 report (Appendix A)
Deaths, suicides, physical health and care plans to note

<table>
<thead>
<tr>
<th>Progress on SLaM MH Law Committee Workplan for high quality, least restrictive care of detained patients</th>
</tr>
</thead>
<tbody>
<tr>
<td>The Quality of ’appropriate’, evidence-based, least restrictive care provided to Slam detained patients</td>
</tr>
<tr>
<td>The Committee noted its responsibility, under its Terms of Reference required by the Board, to ensure that the care provided to patients we detain is of the highest equitable quality, but we are not yet in a position to have routine information to assure that</td>
</tr>
<tr>
<td>Improvement initiative to identify potential opportunities to safely reduce repeat detentions through Quality of care changes</td>
</tr>
<tr>
<td>The MHA Clinical Lead, Dr David O’Flynn will undertake a review of readmissions and re-detentions, and identify the multi-axial needs, access to NICE concordant standards of care, co-produced care plans and other factors of high-quality care that he considers relevant to reducing relapse and re-detentions, and identifying potential improvement opportunities</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Mental Capacity Act Sub-Committee:</th>
</tr>
</thead>
<tbody>
<tr>
<td>▪ Consent and Capacity assessment and recording</td>
</tr>
<tr>
<td>▪ Debriefing the patient experience of detention</td>
</tr>
<tr>
<td>The Committee received a report from the MCA Sub-Committee. Improvement proposals include:</td>
</tr>
<tr>
<td>(a) a QI project to explore a person’s experience of the detention process and link this to an advance care planning project and</td>
</tr>
<tr>
<td>(b) that each Operational Directorate nominate a</td>
</tr>
<tr>
<td>MCA Sub-Committee Actions:</td>
</tr>
<tr>
<td>Debriefing models post detention to understand and improve the patient experience:</td>
</tr>
<tr>
<td>SLaM MH Law Committee is committed to routine debriefing. Models of debriefing to be explored with South London Partners (SLP) e.g. Oxleas who have expertise using their peer experts.</td>
</tr>
<tr>
<td>Advance care plans: The Sub-Committee agreed to explore advance care planning learning from work in progress on a Lambeth ward and input</td>
</tr>
</tbody>
</table>
from the consultant

**Capacity champions:** the Trust MCA Clinical Lead will work up a case for change to have a capacity champion in each Operational Directorate given the consistent findings of CQC Regulatory breaches

**Information content and use Action:**

Members of the Operational Directorate Mental Health Law Committees consider Options 1 and 2 of the information plan.

**Data literacy training** be provided to the Operational Directorate medical leads, other service and clinical leaders. That there is a dedicated support session to assist them to understand the new dashboards now available to them

**Borough Clinical data champions:** The four Borough Operational Directorates to identify a lead who could become the ‘data’ champion. This could be from any discipline but needed to be someone interested to develop data literacy skills.

**Data quality assurance** with links to CRIS is also an action to scope as fundamental to floor to Board good governance

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**Work plan on Accessible Information, informatics and digital**

The Chair restated that two distinct information sections need to be available to the medical and service leads to address our Board mandated Terms of Reference (ToR). Information that tells us:

(a) Are we meeting the legal, regulatory standards and Mental Health Act Code of Practice standards?
(b) When we detain people, are we are delivering the right care to them within a human rights/equalities’ framework; and in the least restrictive manner

There are two options on how best to provide the information for the Operational Directorates:

**Option 1:** expanding the core dedicated Mental Health Act dashboard;

**Option 2:** Embed ethnicity and detention status in all analyses and reports especially, in those presented to the Quality Committee, Workforce and Equalities Committee, and the monthly Board reports.

**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.

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**Key points of assurance**

**The MH law Committee is continuing to make progress on delivering its workplan of**

- **Strengthened governance by Slam Board and SMT** with mental health Act matters now reported in the monthly routine local, SMT and Board Quality and Performance reports. Improvement actions necessary to deliver legal standards are progressing well through Flow plans, CEO’s mandated ‘No’ S 136 breaches and no ED 12 hour breaches, Multi agency partnerships solution focussed meetings (MADE events), and QI work.

- **Strengthened and reorganised Local floor to Board Governance** to take account of Slam’s reorganisation into local borough operational delivery units. There are now regular, formal local MH law meetings to identify challenges, agree improvement plans with local SMTs and report progress and actions that require trustwide action to the MH Law trustwide Committee.

- **Strengthened and dynamic clinical leadership at** local MH Law governance and developing competency-based training to complement the didactic MH law ‘facts’ training

- **User and carer leadership at the M H Law trust wide Committee** with excellent improvement suggestions

- **Improved information on standards, and responsive improvement plans to enable floor to Board review.** The routine reporting of S 136 and community assessments has identified the level of challenge in meeting the legal standards and there are robust Flow improvement processes in place.

- **Improved information on Equalities relating to the levels of overrepresentation of people from BAME communities,** particularly part 3 ‘Forensic’ detentions and improvements are planned in
liaison with Slam’s Public Sector equalities and Black Thrive partner programmes

g) **The commitment and energy of the MH Law Committee members and the Exec lead at Trustwide and local operational delivery unit levels** to understand and improve the patient experience, debriefing, quality of care, equalities, least restrictive options, potential for safe, avoidable reductions, digital tool development to improve standards and Quality improvement initiatives.

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

i) 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: 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.

Slam Good practice points for the attention of the Board:


k) The Trust’s inclusion of MH Act data in the Trust Board monthly performance, activity and quality reports, is a model of excellence and not common in Mental Health Trusts. The Executive Team should be congratulated on this priority given to the use of the Mental Health Act.

l) The establishment of clear “Floor to Board’ MH Law governance Committees is excellent.

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<table>
<thead>
<tr>
<th>Key risks to flag</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Information Quality</strong> Accurate information, derived from high data entry and quality is important to enable good governance. The various benchmarking sources are inconsistent</td>
</tr>
</tbody>
</table>

S 140 local commissioning arrangements and Delayed MHA Assessments – 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.” S140 failure to provide services including beds for patients is a breach of the MHA. Delays with MHA assessment completion poses a risk to the patient and potentially other persons and has been identified by CQC and coroners as a national concern.

Section 135 and section 136 overstays by persons in the Health Based Place of Safety (HBPoS) beyond the 24-hour assessment 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, the South London Partnership and the wider London region.

Clinical standards of care for detained patients: we do not yet have the full routine information we need to assure the Board that our care of detained patients is of the highest quality and is the least restrictive. CQC finds consistent gaps in our standards of Information giving, assessment and recording of consent and capacity and coproduced care planning.

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. The MH Law Exec lead has written to the Executive Nursing Leads in the four partner Acute Trusts seeking clarity regarding what formal governance processes they have in place to

- oversee the use of the MHA and the Service Level Agreements for MH law administration and the care provided by the SLaM psychiatric liaison service and any supports needed

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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 January 2019 Quality Committee
Appendix A: Benchmarking Slam MH act

3 data sources:
- NHS benchmarking data
- Pan London CEO commissioned data on S 136 use, Casemix, BAME, standards of assessment,
- CQC SLAM November 2018 Insight report

1. NHS Benchmarking 2018 Information (SLAM=red bar with Other London Trusts =Green bar)

Patients detained under the MH Act have longer lengths of stay and this is of note in Slam, which has less readmissions
The majority of admissions under the Mental Health Act use Section 2 which initially allows for up to 28 days detention. Patients in this group, however, often have a longer length of stay. This year’s average of 41.3 days for detained patients compares to 44.6 days last year. Average length of stay for patients not detained under the Act remains less, and the average position including both detained and not detained patients is 30.8 days this year. Use of the Mental Health Act reflects patient acuity and risk, and impacts directly on each provider’s average length of stay position across all admissions.

![Chart showing adult acute mean length of stay for MHA detentions](image)

**Figure 16**

**Trends in types of detentions show maximum use of S 2 and S 3, Data quality: This is at variance with Slam’s own BI information on our use of S 136 detentions**

The chart below shows individual provider (inner ring) and national (outer ring) positions relating to use of the Mental Health Act. If only one ring is shown, this is the national position. Admissions under the Mental Health Act are shown here, and all bed types are included.

Section 2 remains the most often used part of the Mental Health Act, with 75% of MHA admissions being under Section 2. Sections 2 and 3 together represent 95% of all MHA admissions, and in some organisations all admissions under the Mental Heal Act are via one of these routes, usually due to the lack of forensic services in these organisations.

![Pie chart showing percentages of MHA admissions by section](image)

**2. Pan London CEO commissioned Mental health act information on S 136 and AWOLs**

**Jan 2019 report**

**A note about data quality**

With the exception of C & I, all data has been collected from MHDS provider extracts (formerly MHMDS and MHLDDS). Counts of Section 136 activity should be interpreted with a little caution due to the limitations of MHDS and issues with data quality. In particular, when the system switched across from MHLDDS to MHSDS early in 2016, some Section 136 activity was undercounted.

There are a number of other data quality difficulties which can affect accuracy. These can be summarised as follows:

- Ward stays are not always recorded comprehensively for patients admitted following section 136 - affecting the calculation of section 136 outcomes
- Evidence of different patient ids being used for the same patient – affecting the calculation of repeat section 136 activity
- Errors in recording of section 136 start and end times – affecting the accuracy of calculated processing times
- Missing NHS numbers preventing the identification of repeat section 136 activities
Slam and S 136: conveyance by ambulance not police vehicle as requires by the Code of Practice

The collection of processing time data started in October 2017 and so a complete 12-month period of information is now available. ELFT process Section 136 patients more quickly, dealing with 85% of patients in under 12 hours. SLAM deal with patients more slowly and only 28% are processed within 12 hours and a quarter take longer than 24 hours. However, difficulties arise when comparing MHTs using this measure. For example, SLAM deal with considerably more patients than ELFT and patient outcomes are quite different between the two MHTs. (Pages 79 – 82)

Almost 50% of people are conveyed to hospitals in Police vehicles and not in Ambulance services as mandated in the Code of Practice

<table>
<thead>
<tr>
<th></th>
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<tbody>
<tr>
<td>Metropolitan Police Dec 2016 - Nov 2017</td>
<td>Metropolitan Police Dec 2017 - Nov 2018</td>
</tr>
</tbody>
</table>

London benchmarked use of S 136

The number of occasions that Section 136 Mental Health Act 1983 was used, May 2016 – Apr 2018

<table>
<thead>
<tr>
<th>2016</th>
<th>2017</th>
</tr>
</thead>
<tbody>
<tr>
<td>May</td>
<td>June</td>
</tr>
<tr>
<td>BEH</td>
<td>44</td>
</tr>
<tr>
<td>C &amp; I</td>
<td>60</td>
</tr>
<tr>
<td>CNWL</td>
<td>35</td>
</tr>
<tr>
<td>E LONDON</td>
<td>21</td>
</tr>
<tr>
<td>NELFT</td>
<td>44</td>
</tr>
<tr>
<td>OXLEAS</td>
<td>22</td>
</tr>
<tr>
<td>SLAM</td>
<td>44</td>
</tr>
<tr>
<td>SWLSTG</td>
<td>33</td>
</tr>
<tr>
<td>WLMHT</td>
<td>42</td>
</tr>
<tr>
<td>Total</td>
<td>417</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>2017</th>
<th>2018</th>
</tr>
</thead>
<tbody>
<tr>
<td>May</td>
<td>June</td>
</tr>
<tr>
<td>BEH</td>
<td>41</td>
</tr>
<tr>
<td>C &amp; I</td>
<td>35</td>
</tr>
<tr>
<td>CNWL</td>
<td>74*</td>
</tr>
<tr>
<td>E LONDON</td>
<td>46*</td>
</tr>
<tr>
<td>NELFT</td>
<td>40</td>
</tr>
<tr>
<td>OXLEAS</td>
<td>45</td>
</tr>
<tr>
<td>SLAM</td>
<td>88</td>
</tr>
<tr>
<td>SWLSTG</td>
<td>38</td>
</tr>
<tr>
<td>WLMHT</td>
<td>54</td>
</tr>
</tbody>
</table>

Source: S136DE excepting C & I which is drawn from local systems. S136DE data was supplied as a quarter total for Jan-Mar 2017 and as monthly estimates were used. * From April 2017 all Section 136 activity for CNWL & ELFT patients with home addresses outside Greater London were excluded from the counts. This was done to maintain the credibility of the analysis now that CNWL and ELFT provide Section 136 places of safety outside London. A complete explanation is published in Appendix B.
An overview of Section 136 usage across all London Mental Health Trusts

The upper charts are based upon data collected since monitoring began. The lower charts compare the most up to date information for the last four 12-month periods. Some gaps exist in the data supplied by MHTs & this can be identified from blanks or low number counts on pages 90 – 92

Repeat Section 136 presentations by the same patient (within the same MHT) Oct 17 – Sep 18

Interpretation: In SLAM, 523 patients were detained on 1 occasion only using section 136, 45 patients were detained twice, 7 patients were detained 3 times, 2 patients were detained 4 times etc during the year. 11% of patients were detained on two or more occasions.

Usage of Section 136 Mental Health Act 1983 by ethnicity, year-on-year comparison – SLAM

The information on this page allows comparisons between the previous 4-year periods ending in September 15/16/17/18.

The chart displays over-representation by bars above the zero axis – positive numbers and under-representation by bars under the zero axis – negative numbers.

Unusually the Asian category is over-represented, but this is possibly due to the fact that only 2% of residents within the SLAM area classify themselves as Asian and so a small departure by just 1 percentage point exercises a large influence on the calculation of disproportionality. See 3rd row of the table.
Section 136 Age profile, years ending Sep 2016, Sep 2017, Sep 2018

AMHP assessment timescales

Section 136 assessments at places of safety – AMHP Timeliness – Office Hours: Q3 2014 – Q4 2018

The percentage of occasions where more than 6 hours elapsed between the time that an AMHP was requested to attend the place of safety and the time that an AMHP arrived. Q4 2016 does not include December and this will be added at the next update.
Overview of AMHP responses to places of safety for years ending Nov 15 / Nov 16 / Nov 17 / Nov 18

The red line indicates an aspirational target of 25%. Performance below this line indicates that excessive delays occurred on less than 1 in 4 occasions.

Section 136 assessments at places of safety – Timeliness of Doctors – Office Hours: Q3 2014 – Q4 2018

The percentage of occasions where more than 3 hours elapsed between the patient’s time of arrival in the place of safety and the time that an assessment by a doctor began. Q3 2018 does not include December and this will be added at the next update.
Timeliness/Availability of AMHPs and Doctors
During the most recent 12-month period, BEH, NELFT and WLMHT have been unable to meet the target for AMHP arrival within 4 hours during office hours. **SWLSTG and SLAM have demonstrated the best improvement in this area.** As far as AMHP performance out of hours is concerned BEH, NELFT and WLMHT have struggled to achieve the target but SWLSTG and SLAM have shown the best improvement. All MHTs have achieved good performance with Doctor arrival times within office hours. SWLSTG has not met the out of hours Doctor attendance target but is now showing signs of rapid improvement.

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AWOLs
Total number of AWOL Episodes reported by MHT, for each quarter in the period Q3 2014 – Q4 2018

Q3 2018 does not include December and this will be added at the next update.

Overview of Total AWOL reports by MHTs in London for period Jun 2014 – Nov 2018
AWOL episodes per 100 detained patients comparisons ending Nov 15 / Nov 16 / Nov 17 / Nov 18

Year on year comparison AWOL episodes per 100 detained patients

The figures in this chart are monthly averages for the years shown.

Reported AWOL Episodes By CQC Category – comparison for years ending Nov 16 / Nov 17 / Nov 18

OXLEAS

SLAM

Requests to police to assist ward staff, manage a difficult, aggressive, disturbed patient Dec 17 – Nov 18

Explanatory Note
N/A

In the absence of feedback in support of its retention, monitoring of this area is likely to cease in the near future.
3. **CQC SLAM Insight Report Jan 2019 (focus on MH act benchmarking)**

**Complaints by people detained**

### Complaints and Notifications

#### Mental Health Act Complaints

CQC received 74 Mental Health Act complaints for this provider from 01/12/2017 to 30/11/2018.

<table>
<thead>
<tr>
<th>Location</th>
<th>Total number of complaints</th>
</tr>
</thead>
<tbody>
<tr>
<td>The Bethlem Royal Hospital (Rv309)</td>
<td>32</td>
</tr>
<tr>
<td>Lambeth Hospital (Rv300)</td>
<td>15</td>
</tr>
<tr>
<td>Maudsley Hospital (Rv506)</td>
<td>12</td>
</tr>
<tr>
<td>Ladywell Unit (Rv500)</td>
<td>12</td>
</tr>
<tr>
<td>Heathcote Close (Rv501)</td>
<td>2</td>
</tr>
</tbody>
</table>

### Complaints and Notifications

#### Deaths of Detained Patients

CQC received 5 notification(s) of death(s) that occurred at this provider for the period 01/01/2018 to 31/12/2018. Summary details of deaths are listed in the table below:

<table>
<thead>
<tr>
<th>Reference number</th>
<th>Date of death</th>
<th>Location</th>
<th>Ward</th>
<th>Cause of death</th>
<th>Additional information</th>
<th>Notification received within 3 days</th>
</tr>
</thead>
<tbody>
<tr>
<td>4629</td>
<td>12/05/2018</td>
<td>Maudsley Hospital</td>
<td>Maudsley Hospital CTU (No Detained Patients)</td>
<td>2 - Natural Causes</td>
<td>-</td>
<td>No</td>
</tr>
<tr>
<td>4691</td>
<td>02/07/2018</td>
<td>Lambeth Hospital</td>
<td>Lambeth Hospital: Notson Ward</td>
<td>2 - Natural Causes</td>
<td>-</td>
<td>No</td>
</tr>
<tr>
<td>4674</td>
<td>24/06/2018</td>
<td>Lambeth Hospital</td>
<td>WARD IN THE COMMUNITY</td>
<td>7 - Not Known</td>
<td>-</td>
<td>Yes</td>
</tr>
<tr>
<td>4622</td>
<td>31/03/2018</td>
<td>Lambeth Hospital</td>
<td>Lambeth Hospital: Tony Hill Unit (NOW AT BETHLEM) UNTIL OCT 014</td>
<td>2 - Natural Causes</td>
<td>-</td>
<td>No</td>
</tr>
<tr>
<td>4790</td>
<td>08/03/2018</td>
<td>Maudsley Hospital</td>
<td>Maudsley Hospital: Elwell Ward 2</td>
<td>7 - Not Known</td>
<td>Death within 7 days of an incident of self-harm. Death within 7 days of the use of restraint.</td>
<td>No</td>
</tr>
<tr>
<td>4722</td>
<td>12/01/2018</td>
<td>Ladywell Unit</td>
<td>The Ladywell Unit: Wharton</td>
<td>9 - Awaiting Information</td>
<td>-</td>
<td>No</td>
</tr>
</tbody>
</table>

**Detained patient deaths: Trusts flagging for risk in the number of suicides of patients detained under the Mental Health Act (all ages)**

<table>
<thead>
<tr>
<th>Date</th>
<th>Death Count</th>
<th>Data supressed</th>
</tr>
</thead>
<tbody>
<tr>
<td>Nov 14 - Oct 15</td>
<td>0.0</td>
<td></td>
</tr>
<tr>
<td>Oct 17 - Sep 18</td>
<td></td>
<td>Data supressed</td>
</tr>
</tbody>
</table>

### Complaints and Notifications

#### Absence Without Leave (AWOL)

No notification(s) of unauthorised absence were received by the CQC for this provider for the period 01/01/2018 to 31/12/2018.

### Second Opinion Appointed Doctor (SOAD) Measures

Below is a table showing a summary of the SOAD visits carried out by the CQC at the provider's request for the period 01/08/2017 to 31/07/2018.

<table>
<thead>
<tr>
<th>Total Number of SOAD Visits</th>
<th>Proportion of visits where problems were reported</th>
<th>Proportion of relevant SOAD visit requests received late</th>
</tr>
</thead>
<tbody>
<tr>
<td>523</td>
<td>11%</td>
<td>31%</td>
</tr>
<tr>
<td>E1</td>
<td>Proportion of detained patient records checked that show evidence of discussions about rights on detention (%)</td>
<td>94.1%</td>
</tr>
<tr>
<td>----</td>
<td>---------------------------------------------------------------------------------------------------------</td>
<td>-------</td>
</tr>
<tr>
<td>E1</td>
<td>Proportion of detained patient records checked where care plans showed evidence of discharge planning (%)</td>
<td>84.2%</td>
</tr>
<tr>
<td>E1</td>
<td>Proportion of detained patient records checked where there was an approved mental health practitioner (AMHP) report available (%)</td>
<td>84.7%</td>
</tr>
<tr>
<td>E1</td>
<td>Proportion of hospital spells under detention (ages 18-84) that finished in the period where patients were readmitted under detention (sections 2 and 3 of the MHA) within 30 days (%)</td>
<td>4.5%</td>
</tr>
</tbody>
</table>

| E1 | Proportion of wards visited where there is an Independent Mental Health Advocacy (IMHA) service available for detained patients (%) | 99.9% | NA | 100.0% | Aug 17 – Jul 18 | NA |
| E1 | Proportion of wards visited where there were difficulties in arranging GP services for detained patients (%) | 13.9% | NA | 18.2% | Aug 17 – Jul 18 | NA |
REPORT TO THE TRUST BOARD: PUBLIC
26 February 2019

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<thead>
<tr>
<th>Title</th>
<th>Health and Wellbeing Board – Health and Care Plan</th>
</tr>
</thead>
<tbody>
<tr>
<td>Author</td>
<td>N/A</td>
</tr>
<tr>
<td>Accountable Director</td>
<td>N/A</td>
</tr>
</tbody>
</table>

Purpose of the paper

For the Board to note the Croydon’s health and care transformation plan, which will be a key delivery plan of the Health and Wellbeing Board’s Strategy, which in turn provides the health and care and in parts the wider determinants response to the Croydon Local Strategic Partnership vision.

The Plan will also inform the South West London Health and Care Partnership Plan which is being refreshed.
Croydon’s Health and Care Transformation Plan

BOARD SPONSOR: Agnelo Fernandes

BOARD PRIORITY/POLICY CONTEXT:
Croydon’s health and care transformation plan will be a key delivery plan of the Health and Well Being Board’s Strategy, which in turn provides the health and care and in parts the wider determinants response to the Croydon Local Strategic Partnership vision.

The plan will also inform the South West London Health and Care Partnership Plan which is being refreshed.

FINANCIAL IMPACT:
Partner Directors of Finance are refreshing the Croydon wide financial position. The position is expected to be similar to that modelled in 2017 with approximately £160m cumulative challenge over 5 years if the system ‘does nothing’.

Our plans are required to improve health and well-being as well as ensure a sustainable health and care system.

1. RECOMMENDATIONS

1.1 To comment on and note the emerging health and care transformation plan

1.2 To note the timetable and to agree the Health and Well Being Board Executive Group sign off the health and care transformation plan discussion document for wider circulation in March. Publication will be in July 2019.

2. EXECUTIVE SUMMARY

2.1 The One Croydon Transformation Board is developing Croydon’s health and care transformation plan.

2.2 It will be a key delivery plan of the Health and Well Being Board’s Strategy, which in turn provides the health and care and in parts the wider determinants response to the Croydon Local Strategic Partnership vision. The plan will also inform the South West London Health and Care Partnership Plan which is being refreshed.

2.3 The plan will not start from scratch or replace individual partner plans, but will build upon them and on specific service strategies, by taking a common lens and identifying key areas of collaboration.

2.4 This report provides the draft plan on page, draft outcomes framework and draft implementation plans. The full plan will be available in March as a discussion document, with the final plan being published in the summer.

3. DETAIL
3.1 One Croydon partners are on a journey to sustainably transform health and care services, working with wider South West London partners where appropriate.

3.2 A number of milestones have provided an opportunity to take stock of the significant progress made over the past years to transform services, to reset the momentum and the scale of transformational change and improvement and to set out Croydon’s health and care transformation plan. These milestones include:

- The One Croydon Alliance Agreement, which sets out how partners will work together, extended its agreement to 2027 in March 2018. It also agreed to extend its term expand the remit of the Alliance Agreement to ensure system transformation for the whole population.
- The development of the Health and Well Being Strategy.
- The expected publication of the NHS Long Term Plan which in turn will need a local response. The South West London Sustainability and Transformation Partnerships is refreshing the South West London strategy and a local health and care plan will inform the South West London Plan.

3.3 A series of sessions have been held over the past months with partners to refresh our outcomes (health and care, system and financial) and to refresh our plans for delivering system transformation for the whole population.

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3.5 Appendix 2 sets out a draft plan on a page, draft outcomes framework and draft implementation plans. System wide programme boards continue to work to refine our plans especially to ensure the engagement event feedback is reviewed and reflected appropriately in the final discussion document.

The draft plan on a page (Appendix 2)

Working together to help you lead your life

3.6 The plan on a page sets out a golden thread from our long term goals, through to our priorities, the approach we will take to all that we do, and finally the initiatives we will focus on. It shows how our plans align with the Health and Well Being Board Strategy.

3.7 In essence our strategic approach is to keep people well. We want people to stay well and we want to prevent things becoming a problem, if people do have a problem we want them to be able to manage well, and have access to the things that will help themselves, and for those that have the greatest need, we want them to have access to services in the right place, at the right time, first time.

3.8 Factors such as the environment we live in, the education we receive and the relationships around us are major contributors to health, accounting for 80% of an individuals’ health and wellbeing. We will work with the wider determinant factors that contribute to the health of residents the most. They each have a role to play in helping people stay well, manage well and supporting people with the greatest need.

3.9 Our strategic initiatives will ensure a whole system shift towards this preventative model of care, including self-care, self-management and personal resilience, with an asset based approach. We know in Croydon there are certain long term conditions that are more prevalent than others and we want to focus on trying to prevent further development of these conditions. Supporting the development of resilient communities will play an important role in individuals become more resilient. Ensuring support and services are tailored to local needs, will add to this resilience.

The draft outcomes framework

3.10 The outcomes framework aligns with the plan on a page, setting out how we will measure long term goals, the outcomes we expect to see in 5 years’ time, and then annual indicators which will show we are heading tin the right direction to make the change we want to see. Currently the
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020 3458 5245

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**BACKGROUND DOCUMENTS:** NONE
Croydon’s health and care transformation plan on a page DRAFT v19

OUR VISION
Working together to help you lead your life

STRATEGIC GOALS AND OUTCOMES

Improve healthy life expectancy
- People are living longer and healthier lives

Reduce Inequalities
- Inequalities of life expectancy between areas is closing

A sustainable health and care system
- Affordable models of care delivering improved outcomes

Peoples aspirations
- I am in control of my own health and well being
- I am able to stay healthy, active and independent as long as possible
- I live in an active and supportive community
- I can access the support my family and I need
- I can access quality services that are created with me and my family in mind

STRATEGIC PRIORITIES

- Enable a better start in life (1)
- Improve quality of life (4)
- Manage Well
- Stay Well
- Improve wider determinants of health and well being (3 / 5)
- Integrate health and social care (6)

STRATEGIC APPROACH (7)

Greatest Need
Manage Well
Stay Well

STRATEGIC INITIATIVES

- People have the support and access in the right place at the right time
- People are able to manage well
- People are able to stay well
- Healthy Weight
- Healthy Mind
- First 1000 days of life
- Immunisation in the Community
- Health, well being and care in all policy
- Housing support for mental health
- Working with schools
- Maximising income
- Supporting Carers
- Integrated Care System
- Population health management and evidenced based delivery
- Locality based care model development
- Integrated, multi skilled workforce, IT and estates
- Multi-disciplinary community led support

(No.) = Supports delivery of Health and Well Being Strategy priority areas
(1) A better start in life, (2) Strong, engaged, inclusive and well connected communities, (3) Housing and the environment enable all people of Croydon to be healthy, (4) Mental wellbeing and good mental health are seen as a driver of health, (5) A strong local economy with quality, local jobs, (6) Get more people more active, more often, (7) A stronger focus on prevention, (8) The right people, in the right place, at the right time
Measuring Success - Croydon’s health and care transformation plan on a page DRAFT v19

OUR GOALS (10 years)

- Improve healthy life expectancy in Croydon from 62 years to 66 years for men and from 62.8 to 66.8 years for women over the next 10 years.
- Reduce premature mortality from 317 (per 100,000) to 250 over the next 10 years.

- Integrated health and care provision that meets people’s aspirations
- Increase the proportion of activity in the community: asset based individuals and communities, voluntary sector, social care, out of hospital setting (further work needed)
- Increase activity in out of hospital settings and reduce unnecessary acute activity shifted to out of hospital setting by 2024
- High level measure on the development of local workforce with health and social care skills to be developed
- Sustainable recurrent health and care financial performance

OUR STRATEGIC OUTCOMES (5 Years)

Health and well being
1. More people will regularly engage in behaviours that will improve their health
2. More people with physical or mental long term conditions and their families and carers will be supported to manage their condition well
3. More people will be able to live well at home for as long as possible

Quality and Appropriateness of Care
4. People will have positive experience and outcomes of health and social care
5. More people will have their health and social care needs met in the community.

Increase families confidence in resilience & self care
6. Fewer children will be living in poverty
7. More children will have a maximised their level of development socially, emotionally and cognitively when they start school
8. More children will be a healthy weight

Increase level of health, connectivity and independence
10. Fewer people will be homeless or living in temporary accommodation
11. People will live in an environment that supports health, connectivity and independence
12. More adults and young people will be economically active or in education or training

Enable a better start in life
13. Effective, multi disciplinary teams around the person providing seamless care
14. Increased proportion spent on prevention and on out of hospital
15. Sustainable health and care provision that meets people’s aspirations

Improve quality of life

Wider determinants of health and well being

Health and well being
1a. Adults taking part in sports and physical activities
1b. Smoking prevalence
1c. Adult obesity
1d. Proportion of people who report good life satisfaction and worth.
2a. Diabetes overall clinical care; people with T2DM that receive all 8 point process OR
2b. Diabetes: estimated diagnosis rate of the estimated prevalence of diabetes
2c. Dementia diagnosis rate
2d. Number of emergency admissions for back, neck and musculoskeletal pain
2e. Long term conditions prevalence gap by indices of multiple deprivation
2a. Excess winter deaths (Is this Transformational?)
3b. People who use social care who have control over their lives

Increase social prescribing coverage
3d ASCOF – social care measures. (tbc)

Quality and Appropriateness of Care
4a. People with long term conditions feel able to manage their condition

4b Person experience and decision making (tbc)
5a. Rate of unplanned hospitalisations aged 65+ for chronic ambulatory care sensitive conditions
5b. Deaths which take place in hospital - all ages
5c. Delayed transfer of care from hospital that are attributed to adult social care
5d. Proportion of people aged 65 and over who were still at home 91 days after discharge from hospital into re-ablement/rehabilitation.

Increased number of community hubs and co-located services in local communities

6a. Children in poverty (under 16)
6a. Low birth weight of term babies
7a. School readiness: maximised level of development at the end of reception year
7b. School pupils with social, emotional and mental health needs
7c. Rate of exclusions in primary and secondary school
8a. Excess weight among children in reception year
8b. Admissions for respiratory tract infections in infants aged 2, 3 and 4
9a. Unplanned hospital admissions for asthma under 19
9c. MMR for 2 doses
9d. Flu vaccinations uptake in at risk groups (Is this transformational?)

10a. Households in temporary accommodation or reduced homelessness?
11a. Air quality indicators
11b. Access to healthy assets
12a. Unemployment rate, maximisation of income and reduction in poverty
12b. Employment of people with mental illness or learning disability
12c. 16-17 year old not in education, employment or training

12d. Increased social inclusion
13a. Recurrent health and social care financial balance
13b. 100% use of Croydon integrated pathways
13c. Reduced spend on private sector
13d. Greater market share of maternity and of planned care in Croydon
14a. Reducing readmission rates
14b. Reducing length of stay
14c. Lower waste on drugs
14d. Lower Do Not Attend rates
15a. Increased multi disciplinary teams
15b. Higher productivity of staff, clinics, theatres, beds, premises.
15c. Reduced social isolation

Page 258 of 271
## Stay Well

### Prevention, Early Intervention, Early Detection
- Develop consistent approach to preventing and proactive management of Long Term Conditions and support for people with disabilities
- Develop a prevention framework
- Review and develop Making Every Contact Count (MECC)
- Review and develop Just Be / Live Well
- Improve national diabetes prevention programme (Healthier You)
- Improve health screening including health checks

### Self Care, Self Management and Personal Resilience
- Expand Healthy pharmacy hub model to all areas of borough
- Create digital version of the Patient Activation Measure (PAM)
- Expand E-Market approach and align with social prescribing

### Active and Supportive Communities
- Build voluntary and community sector partnerships through the voluntary and community sector strategy to deliver whole system prevention
- Develop Local Voluntary partnerships (LVPs), including social prescribing, Asset Based Community Development (ABCD)
- Develop strengths based approaches across disciplines through community led support
- Maxime volunteeing opportunites

### Locality Development
- Develop our locality based, out of hospital care and proactive interventions model, including social care, housing, welfare and universal support
- Implement Gateway Locality Model to strengthen localities in three pilot areas
- Implement Primary Care Working at Scale and development of existing Integrated Community Networks
- Redesign outpatient care
- Improve ambulatory emergency care, redesign of the roving GP, increase 111 offering
- Improve integration between primary and secondary services, social care and housing
- Pathway redesign and process redesign

## Manage Well

### Prevention, Early Intervention, Early Detection
- Develop proactive digital solutions including use and coverage of Health Help Now, service directory and e-market place.
- Develop social prescribing at scale across the borough

### Self Care and Self Management
- Systemise medication reviews for people
- Expand range of options for diabetes structured education (SE)

### Shared Decision Making
- Expand expert patients programme
- Expand group consultation at scale across settings and for all conditions
- Expand Health Help Now e.g. Push notices, Avatars – explain symptoms
- Develop the health champion role
- Roll out Shared Decision Making (SMD) toolkit

## Greatest Need

### Self Care, Self Management & Personal Resilience
- Multi-disciplinary community led support and strengths based approaches for our whole population
- “Nudge theory” to guide behaviour and activities
- Expand LIFE Proactive Community Referrals
- Proactive identification of people in greatest need

### Support Carers
- Extend proactive care management through extended ICNs, Develop LIFE at Scale, Coordinating Care, antibiotics and catheter mgmt.
- Care homes transformation and Assistive Technology
- Transform Falls & Frailty including falls response pilot
- Improve End of Life Care
- High intensity user programme
### PROGRAMMES TO DELIVER OUR INITIATIVES

#### Better Start in Life

- Deliver the All Age Healthy Weight Strategy and pathway
- Implement Early Help Strategy focusing developing resilient families
- A focus on pre-conception health via Sexual health transformation and facilitating healthy behaviour
- Implement the School Superzones Programme
- First 1000 days of life
- Implement Children and young people’s mental health transformation plan
- Healthy Weight - healthy weight prevention and early intervention services
- Healthy Mind – develop and implement a screening tool
- Bringing Immunisation into the community

#### Maternity

- Personalised care and choice of place of birth – personalised care plans, increasing midwifery led care
- Continuity of care – named lead midwife and buddy throughout a women's maternity journey
- Safe care – Multi disciplinary team training on Saving Babies Life's Care Bundle
- Multi disciplinary working and working across boundaries
- Healthy Pregnancy - Immunisations, Breast feeding strategy, parenting support, live well programme
- A fairer payment system

#### Mental Health

- Develop joint mental health strategy to promote good mental health problems and ensure early intervention
- Workplace wellbeing
- Provide the Live Well Croydon and Just Be services to improve mental wellbeing

### Stay Well

- Redesign paediatric pathway
- Expand pathway for A&E Frequent attenders
- Promote GP telephone advice line and asthma nursing service

### Manage Well

- Transforming community mental health provision for people with Serious Mental Illness to include:
  - **Enhance Primary Care** – seamless service between primary & secondary care; improved support & rapid telephone advice for GPs; new primary care mental health support workers; address stigma of mental health.
  - **Community mental health hubs** – common access to primary & secondary care; provision of wide range of services (clinical & social including benefits/housing/employment); link to ICNS.
  - **Improved integrated housing** - develop wide range of housing support options (e.g. The Shared Lives Scheme)
  - **Connected communities** – information, Local Voluntary Partnerships, including social prescribing directory of services galvanise communities, PIC support
  - **Self harm and suicide prevention strategy**

- Talking Therapies – improve access to psychological therapies for people with common mental health problems.
- Dual diagnosis – substance misuse and physical health of people with mental ill health

### Greatest Need

- Develop community therapies strategy
- Redesign Children's community ASD diagnosis and care pathway

#### Alignment with Strategic Priorities

<table>
<thead>
<tr>
<th>Improve Quality of Life</th>
<th>Enable a better start in life</th>
<th>Improve wider determinants of health and well being</th>
<th>Integrate health and social care</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Health and care transformation plan programmes</strong></td>
<td><strong>DRAFT</strong></td>
<td><strong>KEY</strong></td>
<td><strong>Current</strong></td>
</tr>
<tr>
<td>Postnatal care – proactive triage phone calls</td>
<td>Perinatal mental health care - increasing opportunities for identification of those at risk</td>
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</tr>
</tbody>
</table>
### All Age Disability and Adult Social Care Transformation (ADAPT)

- Working age people will have flexible care that they can arrange themselves and have choice and control over, achieved through e-market places, personal budgets and direct payments.
- Transform our provision and workforce to implement locality based, multi-agency working achieving seamless care for people with disabilities, with new front door.
- Children with disabilities – Transforming our practice to provide consistent high quality and proportionate support through childhood and transition to adulthood.
- People will have Active Lives, that are asset based and co-produced with them, ensuring coherent access and promotes inclusion and resilience for people and their carers.
- Improve our housing offer to increase homes and housing options for people with complex health and social care needs.
- Implement digital pathways.

### PROGRAMMES TO DELIVER OUR INITIATIVES

<table>
<thead>
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<tr>
<td>- Implement digital pathways.</td>
</tr>
<tr>
<td><strong>Wider determinants of health and well being</strong></td>
</tr>
<tr>
<td>- Implement Health, prevention and early intervention in all policies (housing, licensing, transport, planning).</td>
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<tr>
<td>- Implement Air Quality strategy.</td>
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<tr>
<td>- Development of Growth Zone.</td>
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<td>- Implement Gateway locality model.</td>
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<tr>
<td>- Implement Homelessness Strategy.</td>
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<tr>
<td>- Implement School Superzones action plan.</td>
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</tbody>
</table>

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<table>
<thead>
<tr>
<th>PROGRAMMES TO DELIVER OUR INITIATIVES</th>
<th>Stay Well</th>
<th>Manage Well</th>
<th>Greatest Need</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>ENABLERS</strong></td>
<td>Development of an integrated care system design options</td>
<td>Joint NHS control total and system financial risk share agreement</td>
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<tr>
<td>Integrated Care System</td>
<td>Business cases for transformation and contracting developments, including shift to outcomes</td>
<td>Total resource sharing and matrix working</td>
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<tr>
<td><strong>ENABLERS</strong></td>
<td>Organisation development</td>
<td>Integrated organisational functions such as placements, safeguarding and quality</td>
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<tr>
<td>Population Health Management</td>
<td>Development and implement population health management strategy</td>
<td>Development and implement population health management function</td>
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<tr>
<td><strong>ENABLERS</strong></td>
<td>Workforce and OD</td>
<td>Shared Business Intelligence – ‘one version of the truth’</td>
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<tr>
<td>Others</td>
<td>Understanding changing workforce requirements</td>
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<tr>
<td><strong>Workforce and OD</strong></td>
<td>Develop and implement a workforce plan</td>
<td>Whole system training solution</td>
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<td></td>
<td>Deliver culture change</td>
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<td></td>
<td>Workforce Well Being</td>
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<tr>
<td><strong>IT and Digital</strong></td>
<td>Interoperability Phase 1 and Phase 2 implementation – primary &amp; secondary care, community and acute and mental health &amp; social care</td>
<td>IT infrastructure development</td>
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<td></td>
<td>Development of effective System IT Transformation Board and work programme</td>
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<tr>
<td><strong>Estates</strong></td>
<td>Capture estates requirements across the system and developing whole system estates solution</td>
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<tr>
<td></td>
<td>Support locality based development including New Addington Health Centre, East Croydon Growth Zone, Coulsdon Health Centre</td>
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<td></td>
<td>Implement ‘One Public Estate’</td>
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<td></td>
<td>Improve GP estate</td>
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<tr>
<td><strong>Communications and Engagement</strong></td>
<td>Communicate and engage with public, staff and stakeholders that supports the One Croydon” approach</td>
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<td></td>
<td>Information and signposting</td>
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<td></td>
<td>Facilitate public consultations where necessary</td>
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<tr>
<td><strong>Finance</strong></td>
<td>Develop whole system financial approaches</td>
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<td></td>
<td>System Risk Share</td>
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<tr>
<td><strong>Contracting &amp; Procurement</strong></td>
<td>Design and implement contracts and appropriate procurement processes to incentivise/support models of care</td>
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</tbody>
</table>

**Alignment with Strategic Priorities**

- Improve Quality of Life
- Enable a better start in life
- Improve wider determinants of health and well being
- Integrate health and social care
Appendix 1

Croydon Health and Care Plan
Feedback from the engagement event
20 November 2018
Since publishing the South West London Health and Care Plan STP Refresh in November 2017, we have been working together to define a case for improvement for Croydon.

We held a partnership health and care event on Tuesday 20 November 2018 to identify shared actions that will have the greatest impact on the issues identified.

Over 160 people attended the event
- Frontline staff – NHS, Local Authority, Voluntary Sector
- Representative sample of local people of the borough
- Community and stakeholder groups

The feedback is being reviewed by our One Croydon programme boards to help inform the development of our Croydon Health and Care Plan. This will be published as a “discussion document” by March 2019. All of the boroughs in South West London will also be doing this in parallel.
Croydon Health and Care Event

Tuesday 20 November 2018

<table>
<thead>
<tr>
<th>Time</th>
<th>Session</th>
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</thead>
<tbody>
<tr>
<td>10.00-10.05</td>
<td>Welcome: Councillor Louisa Woodley, Chair of Croydon Health and Wellbeing Board</td>
</tr>
<tr>
<td>10.05-10.10</td>
<td>We need your help today: Dr Agneso Fernandes, Clinical Chair of NHS Croydon Clinical Commissioning Group</td>
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<tr>
<td>10.10-10.15</td>
<td>Tudor Academy Choir: “We get by with a little help from our friends”</td>
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<tr>
<td>10.15-10.35</td>
<td>Understanding the borough: Rachel Rawlen, Director of Public Health, Croydon Council</td>
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<tr>
<td>10.35-10.50</td>
<td>Introducing Robert’s story: Kate Pogson, Chief Executive Officer, Age UK Croydon</td>
</tr>
<tr>
<td>10.50-11.05</td>
<td>Engagement to date and wider context and challenges: Andrew Byrne, Accountable Officer, NHS Croydon Clinical Commissioning Group</td>
</tr>
<tr>
<td>11.05-11.25</td>
<td>Our Focus Areas today and initial reflections: Guy Van Dichele, Executive Director – Health, Well-being and Adults, Croydon Council and Collaborate</td>
</tr>
<tr>
<td>11.25-11.40</td>
<td>Refreshment break</td>
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<tr>
<td>11.40-12.20</td>
<td>Activity 1: Imaginarium</td>
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<tr>
<td>12.20-13.00</td>
<td>Activity 2: Exploring the focus areas</td>
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<tr>
<td>13.00-13.15</td>
<td>Lunch break</td>
</tr>
<tr>
<td>13.15-14.00</td>
<td>Lunch break</td>
</tr>
<tr>
<td>14.00-14.15</td>
<td>Success stories so far: Noreen O’Dea, Medical Director and Deputy Chief Executive, Croydon Health Services NHS Trust</td>
</tr>
<tr>
<td>14.15-14.30</td>
<td>Activity 3: Ideas into Action</td>
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<tr>
<td>14.30-15.45</td>
<td>Gallery Walk – reviewing the work of our day</td>
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<tr>
<td>15.45-15.55</td>
<td>Reflections from the day</td>
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<tr>
<td>15.55</td>
<td>Next steps and closing remarks</td>
</tr>
<tr>
<td>16.00</td>
<td>Close</td>
</tr>
</tbody>
</table>

Taking action on health and care

What can people do to help themselves manage their health better?

What could we all be doing earlier?

What can be done now to improve support?

What might take more planning?

What could we do to support families, parents and carers?

We believe in an inclusive and innovative approach to care.
We made a film to give people a flavour of the day ...

https://youtu.be/Crg5k-rMges
We believe in an inclusive and innovative approach to care.
166 attendees at the event. Of the 99 participants who completed the feedback form:

- 97% felt the event was valuable
- 98% felt their contribution was listened to
- 58% felt confident that the priorities will make a positive difference to health and care in Croydon
- 72% felt they know more about the health and care partnership than they did before the event
Finalising Croydon’s Health and Care Plan which will...

- Be a delivery plan for the Health and Well Being Strategy
- Be co-designed and owned by both health and local authority partners
- Address the developing health and care needs of the local population
- Outline the vision for health and care locally and the health and care model that are being developed
- Identify and address financial issues in the borough so that we can take a system-wide approach to our collective financial challenges
- Identify and address workforce, clinical and other sustainability issues in the borough
- Outline what the local system will do to support the SWL health prevention/promotion priority (Children and Young People’s Mental Health)
- Allow partners to shape the developing plans through the governance structures in their organisations
Next steps…

- **December/Jan 2018/19:** The film, illustration and evaluation is sent to all those who attended event, together with a note from the HWBB Chair outlining next steps for moving forward together.

- **December 2018 onwards:** Programme Board chairs are to come together to evaluate the outcomes of the day and agree ideas that should be explored further. A proposed priorities will be reviewed by programme boards.

- Updates/discussion at the Health and Wellbeing Boards during **January and February.**

- **Dec – March 2019:** analysis health and care plan initiatives undertaken and priority actions identified.

- **March 2019:** Health and Wellbeing Board receive draft *Health and Care Plans Discussion Documents* for approval, and following this *Health and Care Plans Discussion Documents* circulated to partner organisations for consideration and comment, as well as wider engagement with communities.

- **May – June 2019:** Feedback considered by Partnership Groups and recommendations made for inclusion in the final health and care plan.

- **June 2019:** Final Health and Care Plan presented to the Health and Wellbeing Board for approval.

- **July 2019:** Publication of Health and Care plans.
Board of Directors Meeting
To be held 26th March 2019
2:30pm - 5:00pm ORTUS, Maudsley Hospital

AGENDA: Part 1

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

Opening Matters
Welcome, apologies for absence & declarations of interest and Conflicts of Interest Register 2:45pm Page

Quality
Board Level Review of Serious Incidents Beverley 2:50pm Page
Risk Focus: BAF Risk 2 – Operational Delivery Structure & BAF Risk 3 – Informatics Kris/ Michael 3:05pm Page

The Mental Health Unit (use of Force) Act 2018 Seni’s Law Beverley 3:15pm Page
Performance & Quality Report Kris 3:25pm Page
Guardian of Safe Working Michael 3:40pm Page
Lessons Learnt Beverley 3:50pm Page
Quality Improvement Update Michael/Barbara 4:05pm Page

Medical Recruitment Sally/Mary/Michael 4:15pm Page

Value
Finance Report Gus 4:25pm Page

Updates
Chief Executive’s Report Rachel 4:35pm Page
Council of Governors Update Charlotte 4:40pm Page
Board Assurance Framework Beverley 4:45pm Page
Associated Hospital Managers Approval paper Kay/Beverley 4:50pm Page
Quality Committee Update Charlotte Page
Business Development & Investment Committee Update Adam Page
Financial Performance Committee Update Stephen Page
Oversight & Scrutiny Committee Update Altaf 4:55pm Page
Report from previous month’s Part II Charlotte Page
Wrap-up & Next Meeting 5:00pm Page
Meeting Evaluation tba Verbal

The next Board of Directors Meeting will be held on 23rd April 2019
2:30pm, at the ORTUS, Learning Centre, 82-96 Grove Lane, SE5 8SN.