A MEETING OF THE BOARD OF DIRECTORS OF THE SOUTH LONDON AND MAUDSLEY NHS FOUNDATION TRUST
WILL BE HELD ON TUESDAY 22nd JANUARY 2013 AT 3:00pm BOARDROOM, MAUDSLEY HOSPITAL

AGENDA

1 APOLOGIES for absence:

2 Declarations of Interest

3 Minutes of the Board Meeting held on 11th December 2012
   To receive the Service Quality Improvement Committee Minutes from the November Meeting

4 MATTERS ARISING

QUALITY
5 To receive the Infection Control Surveillance Report

6 To receive the Service Quality Indicator Report

7 To receive the SLaM NICE Annual Report 2012

PERFORMANCE AND ACTIVITY
8 To discuss the Finance Report Month 9

GOVERNANCE
9 To receive a Report from the Acting Chief Executive

10 To receive an Update from the Members Council

11 To receive a verbal Update on King’s Health Partners

12 To receive the Serious Incidents & Patient Safety Annual Report 2011/2012

13 To receive the Assurance Framework Report

14 To receive the Audit Committee Minutes and Signed and Sealed

15 To approve the Audit Committee terms of reference

INFORMATION
16 Director’s Reports

17 Forward Planners

18 Any other business

To consider a motion that representatives of the press and other members of the public be excluded from the remainder of the meeting having regard to the confidential nature of the business to be transacted, publicity on which would be prejudicial to the public interest (Section 1(2) Public bodies (Admission to Meetings) Act 1960

Date of Next Meeting: Tuesday 26th February – 3:00pm, Board Room, Maudsley Hospital, Denmark Hill, London, SE5 8AZ. Please send apologies to Alison Baker 0203 228 4763 alison.baker@slam.nhs.uk

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 person’s role and the business being discussed.

web site: www.slam.nhs.uk

1 of 103
MINUTES OF THE SIXTIETH MEETING OF THE BOARD OF DIRECTORS OF THE
SOUTH LONDON AND MAUDSLEY NHS FOUNDATION TRUST
HELD ON 11TH DECEMBER 2012

PRESENT

<table>
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<tr>
<th>Name</th>
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<tr>
<td>Madeliene Long</td>
<td>Chair</td>
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<td>Dr Martin Baggaley</td>
<td>Medical Director</td>
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<td>Dr Patricia Connell-Julien</td>
<td>Non Executive Director</td>
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<tr>
<td>Robert Coomber</td>
<td>Non Executive Director</td>
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<tr>
<td>Nick Dawe</td>
<td>Interim Director of Finance</td>
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<td>Harriet Hall</td>
<td>Non Executive Director</td>
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<tr>
<td>Gus Heathfield</td>
<td>Acting Chief Executive</td>
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<td>Kumar Jacob</td>
<td>Non Executive Director</td>
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<tr>
<td>Prof Shitij Kapur</td>
<td>Non Executive Director</td>
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<tr>
<td>Prof Hilary McCallion</td>
<td>Director of Nursing and Education</td>
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<tr>
<td>Zoë Reed</td>
<td>Director of Strategy &amp; Business Development</td>
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IN ATTENDANCE

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<tr>
<th>Name</th>
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<tr>
<td>Alison Baker</td>
<td>PA to Chair &amp; Non Executive Directors</td>
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<tr>
<td>Paul Calaminus</td>
<td>Service Director, CAMHS and B&amp;DP CAGs</td>
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<tr>
<td>Lucy Canning</td>
<td>Service Director, Psychosis CAG (item 6 onwards)</td>
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<tr>
<td>Dan Charlton</td>
<td>Head of Communications</td>
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<tr>
<td>Steve Davidson</td>
<td>Service Director, Psych Medicine and MAP CAGs</td>
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<tr>
<td>Paul Mitchell</td>
<td>Trust Board Secretary</td>
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<tr>
<td>Dr John Moriarty</td>
<td>Director of Postgraduate Psychiatric Training</td>
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<tr>
<td>Louise Norris</td>
<td>Director of Human Resources (item 6 onwards)</td>
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<tr>
<td>Noel Urwin</td>
<td>Vice Chair, Members’ Council</td>
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APOLOGIES

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<th>Name</th>
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<tr>
<td>Mark Allen</td>
<td>Service Director, Addictions CAG</td>
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<tr>
<td>Prof Tom Craig</td>
<td>Director of Research &amp; Development</td>
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DECLARATIONS OF INTEREST

Routine declarations were made:

- Madeliene Long declared an interest as a Lewisham Borough Councillor and an Honorary Fellow of King’s College London.
- Zoe Reed declared an interest as Vice Chair, Time Banking UK and as a Trustee of Richmond Borough MIND.
- Patricia Connell-Julien declared an interest as an employee of Kings College London and as Trustee of Southside Certitude Support.
- Hilary McCallion declared an interest as Visiting Professor to South Bank University and King’s College London.
- Prof Shitij Kapur declared an interest as a member of the CNS Scientific Advisory Board of Lundbeck Co and Roche Co. Prof Kapur advises and consults with pharmaceutical companies periodically.
PAUL CALAMINUS
Madeliene Long confirmed that this was the final Board meeting at which Paul Calaminus would be in attendance. She thanked him on behalf of the Board for his outstanding contribution to the development of services within the Trust in a number of different roles during his twelve years at SLaM.

MINUTES
The minutes of the meeting held on the 27th November 2012 were agreed as an accurate record of the meeting.

BOD 139/12 MATTERS ARISING

1) Revalidation of Doctors – BOD 135/12
Dr Martin Baggaley explained that 20% of Consultants would be ready for the next appraisal cycle, it had been a challenge but there was now a more robust structure in place.

BOD 140/12 CONSULTANT APPOINTMENTS
The following Consultant appointments were ratified:

Dr Daniel Harwood – Consultant Psychiatrist, Old Age

The Board of Directors approved the recent Consultant Appointments.

BOD 141/12 POSTGRADUATE MEDICAL EDUCATION PRESENTATION
Dr John Moriarty gave a presentation which informed the Board of Directors of the changes in context of the provision of postgraduate training for doctors, along with the work of the Department in the last year and highlighted risk and challenges for the future.

He explained that Doctors in Postgraduate Training were central to the work of the Trust in two principal ways, firstly they were often at the frontline of service delivery, and secondly the training of doctors and the next generation of psychiatrist were central to the purpose of the organisation. 40 new doctors joined in August 2012, and it was critical to ensure they were adequately trained. Since August 2011 SLaM had been the lead provider for core psychiatric training, and had recently been awarded the LP status for 5 of the 6 higher psychiatry specialities.

Dr Moriarty highlighted a number of practical problems which were hindering the efficiency of the department. The department was expanding and were currently housed across three buildings with the manager not co-located with the team or the Director, which lead to issues with communication and day to day operational and change management.

Although much work had been done to improve the quality of information management locally, they had not managed to secure the IT systems to support more efficient data management. A project to develop a sharepoint based system had been unable to progress.
Gus Heafield commented that these were practical issues which needed to be followed up as a matter of urgency through the Executive. **Action: Gus Heafield**

The Board of Directors noted the presentation.

**BOD 142/12 INFECTION CONTROL REPORT**
Dr Martin Baggaley confirmed that there had been no cases reported within the month. There had been an outbreak of diarrhoea and vomiting on a ward at the Ladywell Unit where four patients had been affected. Following investigations, food was not implicated and the pattern suggested that the outbreak was of viral origin.

The Board of Directors noted the report.

**BOD 143/12 FINANCE VERBAL REPORT – MONTH 8**
Nick Dawe explained that at the end of Month 8 the Trust was reporting a net surplus of £4.4m (£2.8m ahead of the current plan) and EBITA of £11.2m (£1.1m above the current plan). There was an operational deficit of £1.9m at month 8 offset by the contingency reserve, the release of provisions and other non recurring items.

Acute overspill numbers had increased and remained at high levels within Lambeth and Croydon. Steve Davidson explained that it was the first week of opening for the Croydon Triage ward which had eleven beds, they currently had three patients. The ward was beginning to have an impact for the Gresham male ward, which in turn was helping to stabilise the Croydon position.

The Board of Directors noted the verbal report.

**BOD 144/12 ACTING CHIEF EXECUTIVE REPORT**
Gus Heafield explained that a review of ratings for health and social care to be led by Jennifer Dixon would look at whether information from services could be communicated to the public and learn from ‘OFSTED’ style league tables in order to drive improvement.

Dr Jane Sayer had been offered a bursary, the Dame Christine Beasley Leadership scholarship, to develop a bespoke programme to prepare her to increase her skills and build on the leadership capacity within the world of healthcare. Prof Hilary McCallion reported that Natalie Warman had received the same award the previous year.

The FTN were preparing a draft response in regard to the CQC's strategy 2013/6 consultation document, which proposed six strategic objectives which aimed to build the regulators’ credibility and establish a risk based approach to regulating minimum quality standards for health and social care providers.

The Board of Directors noted the report.

**BOD 145/12 UPDATE FROM THE MEMBERS’ COUNCIL**
Noel Urwin explained that results of the elections to the Members’ Council had been announced on Monday 26th November 2012. The new governors would be
invited to attend the next Members’ Council meeting scheduled for Thursday, 13th December. A special meeting of the Members’ Council had been held on 27th November to discuss the implications of the Trust Special Administrator’s report into the future of the South London Healthcare Trust had been a good opportunity to discuss the issues facing the Trust, and contribute towards the response. A joint KHP response was being drafted, and would be shared at the Members Council meeting being held on the 13th December.

The Board of Directors noted the report.

**BOD 146/12 UPDATE ON KING’S HEALTH PARTNERS**

Madeliene Long confirmed that the KHP Partners Board was producing a joint response to the TSA’s report on the future of the South London Healthcare Trust. William McKee, Director of Transition and Transformation would be starting in post the following day. Regular reports on the development of the FBC would be brought back to the Board of Directors. Discussions were continuing with the local MPs regarding the FBC. Madeliene Long reported that the meeting of the Southwark and Lambeth joint scrutiny group had been a good opportunity to promote closer integration across the Partnership.

The Board of Directors noted the verbal report.

**BOD 147/12 DIRECTOR’S REPORTS**

There were no Director’s reports.

**BOD 148/12 FORWARD PLANNERS**

The Forward planner was noted.

**BOD 149/12 ANY OTHER BUSINESS**

No any other business was considered.

The date of the next meeting will be: **Tuesday 22nd January 2013 – 3:00pm**

**Boardroom, Maudsley Hospital, Denmark Hill, London, SE5 8AZ**

Chair
MINUTES OF THE
SERVICE QUALITY IMPROVEMENT
SUB-COMMITTEE OF THE TRUST BOARD OF DIRECTORS
Held on: 27th November 2012 at 9:00AM – 11AM
At: Boardroom, Maudsley Hospital

Present:
Harriet Hall (Chair) Non-Executive Director (HH)
Patricia Connell-Julien Non-Executive Director (PCJ)
Martin Baggaley Medical Director (MB)
Hilary McCallion Director of Nursing & Education (HMC)
Zoe Reed Director of Strategy & Business Development (ZR)
Cliff Bean Deputy Director of Patient Safety & Assurance (CB)
Jenny Goody (Secretary) Interim Governance Manager (JG)
Julie Jones (Minutes) PA to Director of Finance & Corporate Governance (JJ)

In Attendance:
Ray Johannsen-Chapman PPI Strategy Lead (RJC)
Michael Holland Associate Medical Director (MH)

Apologies:
Gus Heafield Acting Chief Executive
Nick Dawe Interim Director of Finance & Corporate Governance
David Norman Service Director (MHOAD)
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<tr>
<td>1.</td>
<td>Apologies</td>
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<td></td>
<td>As received above.</td>
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<td>2.</td>
<td>Declarations of interest / notifications of any other business</td>
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<td>No declarations of interest or notification of any other business were received.</td>
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<td>3.</td>
<td>Minutes of SQUISC Meeting on 4th September 2012</td>
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<td>The minutes were agreed as an accurate record, although HMC asked for the wording at the end of the first paragraph of Item 7 to be clarified.</td>
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<td>4.</td>
<td>Action Point Tracker: Outstanding Actions &amp; Closures</td>
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<td><strong>Action 35:</strong> CB confirmed that the PSTS Policy has been amended and approved by the Prevention and Management of Violence &amp; Aggression (PMVA) Group. <strong>CLOSED</strong></td>
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<td><strong>Actions 36 &amp; 37:</strong> ZR offered to undertake these actions now that Paul Calaminus has moved to another role.</td>
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<td><strong>Actions 38 &amp; 39:</strong> CB confirmed that these actions are underway.</td>
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<td><strong>Action 40:</strong> HH noted that progress towards completing this action was hampered by higher priorities facing the Business Intelligence team.</td>
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<td><strong>Action 41:</strong> JG confirmed that the working of AF risk TW45 has been clarified. <strong>CLOSED</strong></td>
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<td><strong>Action 42:</strong> JG confirmed that monitoring section of the Risk Management and Assurance Strategy has been updated to reflect the wishes of this committee. <strong>CLOSED</strong></td>
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<td><strong>Action 43:</strong> There was some discussion as to how monitoring quality initiatives arising from CQIN and Quality Sanctions can be achieved without duplicating the work undertaken by other committees. ZR commented that exceptions are currently identified through the CEO PMR process and are reported to the Trust Executive and on to the Board of Directors via the Chief Executive’s Report. HH responded that she is looking for a Trust-wide overview of progress to gain assurance that the targets, and associated quality improvements, will be achieved. A new committee, the Quality Programme Delivery and Assurance Group, has been set up, which reports in to the Service Quality Improvement Committee and is responsible for the delivery of the quality targets expressed within the Quality Strategy, the Quality Account and the programme of improvements required to meet CQUIN targets; reporting requirements from this committee into the Service Quality Improvement Committee have yet to be confirmed. <strong>Action:</strong> Work with ZR to develop a quarterly Trust-wide overview of progress towards achieving the Trust’s quality targets.</td>
<td>JG/ZR</td>
<td>Feb-13</td>
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<td><strong>Action:</strong> Work with HMC and MB to clarify the reporting arrangements from the newly formed Quality Programme Delivery and Assurance Group to the SQISC.</td>
<td>JG/MB/HMC</td>
<td>Feb-13</td>
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<td>HMC also questioned the membership of the committee: a CAG Director (DN) and a Head of Nursing (alternating between Julie Heyward, Elaine Rumble and Michael Buxton) are named within the committee’s Terms of Reference but have not attended for some time; it was agreed that these should be removed from the membership of the committee. It was noted that a third Non-Executive Director will be joining the committee once the vacant post has been appointed. <strong>Action:</strong> Update the Terms of Reference of the SQISC, subject to the outcome of the above actions.</td>
<td>JG</td>
<td>Feb-13</td>
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# EXTERNAL QUALITY REPORTING

## 5. Quality Account consultation

CB introduced a ‘Long list’ of possible priorities to be included in the annual Quality Account for 2013/14. The 2012/13 Quality Account was aligned to the Quality Strategy, with no consultation with external stakeholders, a decision that was criticised by External Audit. CB proposes to follow the example of KCH and GSTTH this year, by distributing a list of possible priorities and gaining the consensus of all stakeholders, both internal and external. CB stressed the need to balance corporate and clinical priorities and ensure that CAGs, who will need to deliver the targets, are fully engaged in the process. HMC commented that the Winterbourne and Francis reports are soon to be published and may impact the Trust’s quality priorities. HMC commented that Violence & Aggression is still the biggest issue facing the Trust; ZR asked if the majority of violent incidents occur in the community and whether the quality target should be amended to reflect this - CB confirmed that this was not the case, the vast majority of reported incidents are from in-patient units, and violence and aggression experienced by people with mental health problems in the community is largely unreported.

HH questioned how the final decision will be made, as the way in which the priorities are described and the specific priorities of each voter could distort the results. CB agreed that a straightforward ‘first past the post’ voting may not be fair, depending as it would on voting patterns; ZR suggested inviting the views of a wide variety of stakeholders and weighting their responses in some way. HH stressed that the targets should be related to existing quality initiatives, and we should be careful not to publish an unrealistic list of new priorities and targets.

CB thanked the committee for their input and HH offered to work with him to take this forward.

**Action:** Facilitate a robust Quality Account consultation process and report back to the next meeting of the SQISC.

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<td>5.</td>
<td>CB/HH</td>
<td>Feb-13</td>
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# QUALITY IMPROVEMENT

## 6. Focus on PATIENT EXPERIENCE priority

### National Patient Survey Results

RJC gave a brief presentation on the results of the National Patient Survey, published in September 2012. The rating methodology has changed from previous years: Trusts are no longer measured within Top 20, Middle 60 and Bottom 20 percentages, now a score in the amber section is considered ‘about the same’ as most other trusts, a score in the red section is considered ‘worse’ than most other trusts and a score in the green section is considered ‘better’ than most other trusts.

RJC gave a brief snapshot of SLaM’s results, most of which were rated Amber, with one Red and one Green. There has been a significant improvement in the question ‘Were the purposes of the medication explained to you?’ (7.5 (Red) to 8.3 (Amber)) and ‘Were you told about possible side effects of the medication?’ (5.2 (Red) to 5.7 (Amber)), ‘Do you understand what is in your care plan?’, however, has fallen from 7.0 (Green) to 6.7 (Amber). The Trust received the second highest in the country for ‘Did you find the NHS talking therapy you received in the last 12 months helpful?’ (7.3 (Amber) to 7.9 (Green)) but the lowest in the country for ‘Have NHS mental health services involved a member of
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<td>6.</td>
<td>Could you imagine wanting or knowing that your family or someone else close to you, as much as you would like? (5.9 (Amber) to 5.3 (Red)). RJC pointed out that the new methodology doesn't take ethnicity and deprivation into account; if the scores were weighted for these two factors SLaM would have been placed 6th nationally rather than 13th. Underperforming areas and their improvement action plans will be re-assessed through the Trust's internal PEDIC surveys and the Trust is implementing a 'Friends and Family Test' pilot to assess improvements relating to the 'family and carers' question where SLaM's score was Red. HH asked whether anything from the National Patient Survey results should be included in CB's list of quality priorities; RJC responded that Safety scored highly in the survey, despite being the Trust's highest priority. Other areas of concern are already included with CQUIN targets. HH thanked RJC for his very informative presentation.</td>
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<td>7.</td>
<td><strong>Quality Strategy – Progress</strong> CB reported the Trust’s progress towards achieving its Quality Strategy, which highlights the issue of inadequate data. There are initiatives to meet the Violence &amp; Aggression and Patient Experience targets, but action on the other priorities is limited. Paired HoNOS scores (Clinical Outcomes priority) are not improving and the CAGs do not have the resources to address this by providing feedback to all teams. HH commented that the position doesn’t appear to have improved generally; some access targets have still not been identified due to a lack of data. MB responded that when the constant changes, such as commissioner disinvestment, are taken into account the results actually represent an improvement. CB commented many of the factors affecting performance against the targets have deteriorated. HH concluded that we are half way into a 3-year strategy, and the Board need to know that the targets are not being achieved, despite the considerable effort being made. HH proposed to report to the December Board that the Trust is in danger of not achieving its Quality Strategy and the reasons why; the Board also needs to be made aware of the problem relating to a lack of supporting data caused by the competing priorities of the Business Intelligence unit. HH requested further thoughts from members of the committee to help to draft this report.</td>
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<td>8.</td>
<td><strong>Focus on SAFETY priority</strong> <strong>Patient Safety Improvement</strong> MH presented a model of safety culture based on four main drivers for organisational improvement: Leadership &amp; Culture, Measurement, Quality Initiatives and Capability. The committee discussed the ten key initiatives that need to be addressed and it was agreed that more leadership walkarounds are required at every level, as well as greater clarity around structures for QI delivery. HMC commented that funding for these initiatives comes from the Maudsley Charity and is sometimes difficult to obtain; costs are now being assigned to Serious Incidents as a way of justifying investment in prevention. MB commented that a great deal is being done within the Trust to improve patient safety and that this now needs to be combined into a structured programme. HH</td>
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**Action:** Provide comments relating to the Trust’s progress towards achieving its Quality Strategy to HH, to be incorporated into a report to the December meeting of the Board of Directors. **All** **ASAP**
asked what needs to be influenced; MB responded that violence & aggression, homicide / suicide, medication errors, physical healthcare issues and neglect (in the community) are the major causes of concern. HMC responded that incidents of suicide and homicide have reduced and that risk assessment, multi-agency communication and speed of response are key. MH commented that a consistent, sustainable QI programme to raise cultural awareness of patient safety is required. HH thanked MH for his thought-provoking presentation and suggested that a Board Seminar based on this should be held.

**Action:** Work with the Board of Directors to incorporate ways to achieve the Quality Strategy in its discussions.

**SCRUTINY & ASSURANCE**

9. **Service Quality Assurance Framework**

ND was unable to attend the meeting and so JG presented the Service Quality Assurance Framework (AF), which comprises the principal clinical risks that threaten the Trust. An additional column, the Direction of Travel has been added to the report so that progress towards mitigating these risks can be easily assessed. There are currently 20 Service Quality risks within the Assurance Framework, 8 of which are rated 16+ (Red); there are also 2 Amber rated risks that have a Red delivery status. The following risks were discussed in detail:

**TW45 (Inpatient Safety Alarms):** A Project Manager is now in place; a further business case for funding is due to be presented to the Capital Review Group in Dec-12.

**TW16 (Safeguarding Vulnerable Adults):** The new configuration of the service is due to be implemented in Jan-13.

**ST21 (Quality Strategy supporting data):** The lack of progress because of competing priorities for Business Intelligence needs to be reported to the Board; Business Intelligence resourcing is a recognised issue.

**ST16 (Regulatory Requirements):** This is being reviewed at CEOPR.

It was agreed that the following risks can now be designated as inherent because their current risk grading equals their target risk grading and no further actions are planned:

**TW27 (MHA compliance – non-compliance with Section 58):** Electronic forms are now used to send requests from Responsible Clinicians to the SOAD service, which has greatly reduced the gaps in controlling this risk.

**TW50 (Suicide using non-collapsible rails):** All non-collapsible curtain rails have now been replaced.

**RISK IDENTIFICATION**

10. **Quality Issues Report**

JG presented a brief report of quality issues identified by the Trust leads for serious incidents and compliance with the Mental Health Act. There has been a marked increase in violent incidents at River House in Q2, resulting in a significant loss of staff days due to injury. CB questioned whether there was a robust risk reduction plan for River House; HMC responded that a plan was being worked on with senior managers. Bed occupancy has been reduced and the situation is gradually improving. There are some major issues relating to nursing staff witnessing violent incidents on this unit and the Trust needs to plan how to support them.
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| 11.  | **Sub-committee Escalation Reports**  
      The Risk Management Committee had no issues to escalate at this time.  
      The Quality Governance Committee has not met since the last meeting of the SQISC. | | |
| 12.  | **Feedback to Board of Directors & Audit Committee**  
      It was agreed that the danger of not achieving the Trust’s Quality Strategy should be escalated to the Board of Directors in December.  
      The Audit Committee will receive a highlight report comprising a précis of the meeting minutes for information. | | |
| 13.  | **Feedback to RMC and QGC**  
      It was agreed that there were no urgent issues that need to be fed back to the Risk Management or Quality Governance committees at this time; they will be provided with a highlight report comprising a précis of the meeting minutes for information. | | |
| 14.  | **Forward Planner**  
      The Forward Planner for 2013 was noted by the committee. | | |
| 15.  | **Any Other Business**  
      No other items were raised by the committee. | | |
| 16.  | **Date, Time and Venue of Next Meeting**  
      The date of the next meeting will be advised once the Board dates for 2013 have been agreed. | | |
TRUST BOARD OF DIRECTORS – SUMMARY REPORT

Date of Board meeting: 22 January 2013


Heading: - (Strategy, Quality, Performance & Activity, Governance, Information)

Quality

Author: Karen Taylor – Assistant Director of Nursing – Infection Control

Approved by:
(name of Exec Member) Dr Martin Baggaley

Presented by: Dr Martin Baggaley

Purpose of the report:

To inform the Trust Board of Directors of: Infection Control data, with particular reference to MRSA and \textit{E. coli} bacteraemia, \textit{C. difficile} and outbreaks and; Progress of the Annual Infection Control strategy.

Action required:

To note the report

Recommendations to the Board:

To note the report

Relationship with the Assurance Framework (Risks, Controls and Assurance):

Compliance with Outcome 8 and the Health & Social Care Act [HSCA].

Summary of Financial and Legal Implications:

None

Equality & Diversity and Public & Patient Involvement Implications:

The report positively supports diversity issues
1. **Surveillance report of Blood borne viruses, alert organisms and outbreaks**

| **MRSA** | Nil cases |
| **CMRSA, PVL* etc** | Nil cases |
| **Antibiotic resistant infections, e.g. ESBL, VRE** | Nil cases |
| **E. coli bacteraemia** | Nil cases |
| **C. difficile** | Nil cases |
| **Hepatitis C** | For the month of December 2012, none of the 10 patients screened for Hepatitis C antibody were positive. |
| **Hepatitis B** | For the month of December 2012, 11 patients were tested for HepBsAg. Following further tests, none were found to be HepBeAg positive. |
| **HIV** | For the month of December 2012, 9 Inpatients were tested for HIV. All results were negative. |

**Diarrhoea and vomiting Outbreaks:**

- **Children & Adolescent Inpatient Unit, Maudsley site [18 beds]** – Commenced 27 November 2012
  4 patients and 2 members of staff were affected. Unit closed 29 November – 1 December 2012
- **Acute Adult Inpatient Unit, Bethlem site [18 beds]** – Commenced 8 December 2012
  2 patients were affected. Unit closed 10 – 15 December 2012
- **Psychiatric Intensive care Unit, [18 beds], Maudsley site** – Commenced 14 December 2012
  4 patients were affected. Unit closed 14 - 18 December 2012
- **Older Adults Community Inpatient Unit [26 beds]** – Commenced 14 December 2012
  4 patients were affected. Unit closed 14 – 20 December 2012
- **Older Adults Inpatient Unit, Maudsley hospital [18 beds]** – Commenced 6 January 2013
  3 patients were affected. Unit closed 7 – 10 January 2013

Following investigations, food was not implicated and the pattern suggests that the outbreaks were of viral origin.

---

* Panton Valentine Leucocidin
** Extended spectrum beta-lactamases; Vancomycin Resistant Enterococcus
2. Progress on the Annual Infection Control audit strategy.

2.1 Audit strategy 2012/2013 & Infection Control dashboard

The Infection Control Team [ICT] uses the audit strategy to ensure that policies have been implemented. Ward Managers, Modern Matrons [MM] and Clinical Service Leads [CSL] continue to complete hand hygiene, commode and decontamination of patient equipment audits on a quarterly basis. The results of the audits for each ward are included in an Infection Control dashboard which is presented at the monthly CEOPMR.

2.2 Infection Control visits to Clinical areas

A “Spotlight” checklist has been developed to assist the ICT with the regular visits to wards. This is to ensure compliance with key drivers, including those set by the CQC, and that IC is part of everyday clinical practice.

The checklist includes standards relating to:
- Cleanliness & tidiness
- Hand hygiene, including “Bare below Elbows”
- Waste Management including Sharps
- Awareness of the name of the Trust Director of Infection Prevention & Control
- Documentation of the cleaning of patient equipment, e.g. mattresses
- Food Hygiene

All Waste Management critical issues are escalated to the Estates & Facilities Department. All findings are fed back to Ward Managers, MM and CSLs.

2.3 Infection Control environmental audits in the Community.

Audits on Community units commenced in October 2012, using a specific audit tool. Educational materials and the Decontamination policy are given to the community teams.

2.4 Main kitchen audits

The standards of cleanliness and tidiness in the Maudsley main kitchen remains high.

The kitchen at Woodlands House had good compliance with current food hygiene legislation when it was audited in December 2012.
# TRUST BOARD OF DIRECTORS

## SUMMARY REPORT

<table>
<thead>
<tr>
<th>Date of Board meeting:</th>
<th>22nd January 2013</th>
</tr>
</thead>
<tbody>
<tr>
<td>Name of Report:</td>
<td>Service Quality Indicator Report</td>
</tr>
<tr>
<td>Heading: - (Strategy, Quality, Performance &amp; Activity, Governance, Information)</td>
<td>Quality</td>
</tr>
<tr>
<td>Author:</td>
<td>Roy Jaggon</td>
</tr>
<tr>
<td>Approved by:</td>
<td>Gus Heafield</td>
</tr>
<tr>
<td>(name of Exec Member)</td>
<td></td>
</tr>
<tr>
<td>Presented by:</td>
<td>Roy Jaggon</td>
</tr>
</tbody>
</table>

### Purpose of the report:
To present to the Board the monthly service quality indicator report.

### Action required:
To review, the service quality indicator report, and note the planned way forward in development over the coming months.

### Recommendations to the Board:
The Board are asked to accept the service quality indicator report and the planned work streams in progressing this further.

### Relationship with the Assurance Framework (Risks, Controls and Assurance):
The report provides quality indicator data for each CAG, and therefore provides a source of assurance of service quality.

### Summary of Financial and Legal Implications:
Quality targets written into the core contract quality schedules this year include; seven day follow-up post discharge, and copies of care plans given to patients.

### Equality & Diversity and Public & Patient Involvement Implications:
There are no immediate or direct implications to equality & diversity or public and patient involvement.
SERVICE QUALITY INDICATOR REPORT

At the November 2012 Trust Board meeting the Service Quality Indicator Report was first presented. This was a monthly report consisting of Monitor targets and internal indicators which was by CAG and provided a year to date view of performance.

This report is aimed to be a monthly report which meets the following:

- a report that encompasses quality indicators (including compliance indicators), patient safety, outcomes and access
- a report that takes account of other reporting routes (external returns and reports to commissioners) and ensures reconciliation and consistency between reports
- a report by CAG
- a monthly Monitor report in support of the quarterly submissions
- a report that provides assurance to the Board of on-going compliance
- a report that includes a CAG commentary

Planned work
This report is still very much work in progress and regrettably due to resourcing issues, it has been necessary to put back the timetable for progressing this further. The planned work is as follows:

February 2013  add patient safety incidents for violence and aggression, medication and patient falls.
March 2013  add waiting times data
May 2013  add outcomes data

Following the meeting in November 2012 and the comments received from the Board at that time, the report has been updated to clarify the contextual activity items and borough based activity has now been provided.

Month 9 (Q3) Commentary
CPA 12m Review: From the beginning of this financial year this indicator has changed from being a proxy measure (contact with a care co-ordinator) to an actual measure of CPA reviews. In Q1 the Trust was only able to achieve 66.4% compliance. In Q2 the Trust made significant inroads to addressing this issue that included a significant data cleansing exercise. However there still remained a large number of service users who required a CPA review. Considerable effort from clinical teams meant that the Trust was able to report 95.5% compliance. The systems and processes we have in place for this indicator are still not as robust as we would like and the impact of this is that performance is likely to oscillate between 91.0% and 96%. This includes areas such as correctly changing the patient’s status from CPA to non CPA at the right time and more regular and more focussed prompt/alert reports. Current performance for Q3 is 92.2%. It is anticipated that the performance for Q3 prior to submission to Monitor will improve partly due to a data cleansing exercise which excludes those patients no longer on CPA but haven’t been changed on the system and due to the efforts of the clinical teams. CAGs are producing trajectories of what can be achieved in the limited time available. Based on this work we would anticipate just meeting this target by the end of the month.
Subsequent to this work we be looking at how we can strengthen the systems and processes to ensure robust reporting and early warning signals that allows sufficient time for remedial action.
## December 2012 - Month 9

### INDICATORS

<table>
<thead>
<tr>
<th>Year to Date</th>
<th>Caseload</th>
<th>CPA</th>
<th>CPA</th>
<th>HTT</th>
<th>Early Intervention</th>
<th>Delayed Discharges</th>
<th>CarePlan Copy Given</th>
<th>Brief/Full Risk Screen</th>
<th>Child Risk Screen</th>
<th>Complaints</th>
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<tr>
<td></td>
<td></td>
<td>7 Day Follow-Up</td>
<td>12 Month Review</td>
<td>Gatekeeping</td>
<td>New Referrals</td>
<td>Discharges</td>
<td>% + -</td>
<td>% + -</td>
<td>% + -</td>
<td>% + -</td>
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<tr>
<td>2011/12</td>
<td>2012/13</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
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### CAGs

<table>
<thead>
<tr>
<th>CAGs</th>
<th>Community Caseload</th>
<th>Community Admissions</th>
<th>Community Discharges</th>
<th>Year to Date %</th>
<th>CPA 7 Day Follow-Up</th>
<th>CPA 12 Month Review</th>
<th>HTT Gatekeeping</th>
<th>Early Intervention New Referrals</th>
<th>Delayed Discharges</th>
<th>CarePlan Copy Given</th>
<th>Brief/Full Risk Screen</th>
<th>Child Risk Screen</th>
<th>Complaints</th>
</tr>
</thead>
<tbody>
<tr>
<td>Addictions</td>
<td>2,737</td>
<td>280</td>
<td>289</td>
<td>95.54%</td>
<td>95.5%</td>
<td>95.5%</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
<td>0.00% - 7.50%</td>
<td>94.60% - 0.40%</td>
<td>97.70% + 17.70%</td>
<td>95.00% - 1.00%</td>
</tr>
<tr>
<td>Behavioural and Developmental Psychiatry</td>
<td>1,197</td>
<td>68</td>
<td>91</td>
<td>93.48%</td>
<td>- 1.52%</td>
<td>96.80%</td>
<td>1.80%</td>
<td>N/A</td>
<td>N/A</td>
<td>0.00% - 7.50%</td>
<td>95.50% + 0.50%</td>
<td>99.40% + 19.40%</td>
<td>81.00% - 15.00%</td>
</tr>
<tr>
<td>Child and Adolescent Mental Health Services</td>
<td>5,474</td>
<td>250</td>
<td>247</td>
<td>90.57%</td>
<td>- 4.43%</td>
<td>95.50%</td>
<td>0.50%</td>
<td>N/A</td>
<td>N/A</td>
<td>0.00% - 7.50%</td>
<td>90.20% - 4.80%</td>
<td>N/A</td>
<td>N/A</td>
</tr>
<tr>
<td>MHCA and Dementia</td>
<td>4,240</td>
<td>235</td>
<td>261</td>
<td>100.00%</td>
<td>+ 5.00%</td>
<td>91.70%</td>
<td>- 3.30%</td>
<td>N/A</td>
<td>N/A</td>
<td>0.00% - 7.50%</td>
<td>95.80% + 0.80%</td>
<td>95.60% + 15.60%</td>
<td>89.00% - 7.00%</td>
</tr>
<tr>
<td>Mood Anxiety and Personality</td>
<td>5,860</td>
<td>63</td>
<td>62</td>
<td>92.98%</td>
<td>- 2.02%</td>
<td>92.50%</td>
<td>- 2.50%</td>
<td>N/A</td>
<td>N/A</td>
<td>0.00% - 7.50%</td>
<td>94.70% - 0.30%</td>
<td>91.60% + 11.60%</td>
<td>91.00% - 5.00%</td>
</tr>
<tr>
<td>Psychological Medicine</td>
<td>1,656</td>
<td>250</td>
<td>121</td>
<td>94.32%</td>
<td>- 0.68%</td>
<td>93.80%</td>
<td>- 1.20%</td>
<td>N/A</td>
<td>N/A</td>
<td>0.00% - 7.50%</td>
<td>91.40% - 3.60%</td>
<td>85.50% + 5.50%</td>
<td>86.00% - 10.00%</td>
</tr>
<tr>
<td>Psychosis</td>
<td>7,558</td>
<td>1,451</td>
<td>2,043</td>
<td>95.12%</td>
<td>+ 0.12%</td>
<td>91.90%</td>
<td>- 3.10%</td>
<td>N/A</td>
<td>100.00% + 5.00%</td>
<td>10.50% + 3.00%</td>
<td>95.20% + 0.20%</td>
<td>95.70% + 15.70%</td>
<td>96.00% + 0.00%</td>
</tr>
<tr>
<td><strong>Totals</strong></td>
<td>28,722</td>
<td>2,597</td>
<td>3,114</td>
<td>95.83%</td>
<td>92.20%</td>
<td>99.80%</td>
<td>4.80%</td>
<td>100.00% + 5.00%</td>
<td>100.00% + 5.00%</td>
<td>4.00% - 3.50%</td>
<td>95.00% + 0.00%</td>
<td>90.80% + 10.80%</td>
<td>90.00% - 6.00%</td>
</tr>
</tbody>
</table>

### Boroughs

<table>
<thead>
<tr>
<th>Boroughs</th>
<th>Community Caseload</th>
<th>Community Admissions</th>
<th>Community Discharges</th>
<th>Year to Date %</th>
<th>CPA 7 Day Follow-Up</th>
<th>CPA 12 Month Review</th>
<th>HTT Gatekeeping</th>
<th>Early Intervention New Referrals</th>
<th>Delayed Discharges</th>
<th>CarePlan Copy Given</th>
<th>Brief/Full Risk Screen</th>
<th>Child Risk Screen</th>
<th>Complaints</th>
</tr>
</thead>
<tbody>
<tr>
<td>Croydon</td>
<td>8,047</td>
<td>653</td>
<td>699</td>
<td>95.54%</td>
<td>95.5%</td>
<td>95.5%</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
<td>100.00% + 5.00%</td>
<td>100.00% + 5.00%</td>
<td>0.46% - 7.04%</td>
<td>92.26% + 12.26%</td>
</tr>
<tr>
<td>Lambeth</td>
<td>8,070</td>
<td>218</td>
<td>408</td>
<td>95.04%</td>
<td>+ 0.04%</td>
<td>100.00%</td>
<td>5.00%</td>
<td>N/A</td>
<td>100.00% + 5.00%</td>
<td>100.00% + 5.00%</td>
<td>1.36% - 6.14%</td>
<td>96.72% + 16.72%</td>
<td>86 - 26</td>
</tr>
<tr>
<td>Lewisham</td>
<td>5,743</td>
<td>227</td>
<td>440</td>
<td>96.32%</td>
<td>+ 1.32%</td>
<td>95.20%</td>
<td>+ 0.20%</td>
<td>N/A</td>
<td>100.00% + 5.00%</td>
<td>95.20% + 0.20%</td>
<td>0.46% - 7.04%</td>
<td>96.28% + 16.28%</td>
<td>62 - 10</td>
</tr>
<tr>
<td>Southwark</td>
<td>6,862</td>
<td>838</td>
<td>878</td>
<td>97.05%</td>
<td>+ 2.05%</td>
<td>99.30%</td>
<td>+ 4.30%</td>
<td>N/A</td>
<td>100.00% + 5.00%</td>
<td>100.00% + 5.00%</td>
<td>1.36% - 6.20%</td>
<td>93.38% + 13.38%</td>
<td>86 + 4</td>
</tr>
<tr>
<td><strong>Totals</strong></td>
<td>28,722</td>
<td>1,936</td>
<td>2,425</td>
<td>95.83%</td>
<td>92.20%</td>
<td>99.04%</td>
<td>+ 4.04%</td>
<td>100.00% + 5.00%</td>
<td>100.00% + 5.00%</td>
<td>4.00% - 3.50%</td>
<td>95.00% + 0.00%</td>
<td>90.76% + 10.76%</td>
<td>90.00% - 6.00%</td>
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</tbody>
</table>

17 of 103
**TRUST BOARD OF DIRECTORS – SUMMARY REPORT**

**Date of Board meeting:** 22nd January 2013  
**Name of Report:** SLaM NICE Annual Report 2012  
**Heading** Quality  
**Authors:** Rosie Peregrine- Jones (Clinical Audit & Effectiveness Manager)  
**Approved by:** Hilary McCallion  
**Presented by:** Hilary McCallion/Rosie Peregrine-Jones

**Purpose of the report:**
To outline progress within the Trust against clinical guidance issued by NICE which are relevant to mental health services over the past 12 months and inform the Trust Board of priorities in 2013/14.

**Action required:**
The Trust Board is asked to comment on the content and suggest any amendments/items for inclusion.

**Recommendations to the Board:**
N/A

**Relationship with the Assurance Framework (Risks, Controls and Assurance):**
The Trustwide NICE Implementation and audit program provides assurance for the following risk in the Assurance Framework: The Trust is unable to demonstrate the clinical quality of its services explicitly.

To ensure compliance with the NICE NHSLA standard at level 3, in Dec 2011, SLaM had to demonstrate the full range of relevant NICE guidance, published in the previous 36 months had baseline gap analyses and an ongoing program of audit and monitoring.

**Summary of Financial and Legal Implications:**
Many of the CQUINs in the SLAM 12/13 quality contract are based on NICE recommendations (e.g. smoking cessation, dementia and antipsychotic prescribing, physical health checks and service user experience in adult mental health). Furthermore, the Commissioning Outcomes Framework includes indicators that are based on NICE quality standards, which set markers of high-quality, cost-effective care, covering the treatment and prevention of different diseases and conditions, and which are linked to outcomes. The NHS Commissioning Board published the final set of indicators for 13/14 in December 2012 to inform clinical commissioning groups in planning for 2013/14. Dementia and antipsychotics, physical health checks, recovery following talking therapies and access to community mental health services and psychological therapies by people from black and minority ethnic groups are included.

**Equality & Diversity and Public & Patient Involvement Implications:**
Implementation of NICE guidance ensures that the Trust moves towards equity of service provision across geographical boundaries and patient groups.
SLaM NICE Annual Report (January-December 2012)

Clinical Audit & Effectiveness Team

14th January 2013

Project Author:
Rosie Peregrine-Jones
Clinical Audit & Effectiveness Manager
SLaM Clinical Audit & Effectiveness Team
111 Denmark Hill, Maudsley Hospital
## Contents

<table>
<thead>
<tr>
<th>Contents</th>
<th>Page No.</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Overview of Trustwide systems and assurances and highlights in 2012</td>
<td>3.</td>
</tr>
<tr>
<td>3. Updates on physical and public health NICE guidance</td>
<td>6.</td>
</tr>
<tr>
<td>4. CAG NICE Updates</td>
<td></td>
</tr>
<tr>
<td>● 4.1 Psychosis</td>
<td>7.</td>
</tr>
<tr>
<td>● 4.2 Behavioural &amp; Developmental Psychiatry</td>
<td>8.</td>
</tr>
<tr>
<td>● 4.3 Mental Health Older Adults</td>
<td>8.</td>
</tr>
<tr>
<td>● 4.4 CAMHS</td>
<td>10.</td>
</tr>
<tr>
<td>5. Corporate NICE Objectives for 2013/14</td>
<td>11.</td>
</tr>
</tbody>
</table>

**Appendices:**

- Appendix 1: Trust NICE Assurance Table

- Appendix 2: SLaM NICE Gap Analyses 2012 Update (see Attachment 1)
1. Overview of Trust-wide systems and assurances and highlights in 2012

At the Trustwide level, governance for NICE in 2012 has been overseen by the Quality Governance Committee (QGC), formerly known as the Clinical Audit & Effectiveness Committee, which has been chaired by the Director of Nursing and Education. At a local level, NICE guidance implementation is monitored at CAG Executives or Clinical Effectiveness Committees. Individual guidelines have designated lead(s) who may set up steering groups to support their work or they may report to existing committees e.g. the Physical and Public Health Committee. The ‘Implementing NICE guidance and National Confidential Enquiries in SLaM’ policy (August 2011) underpins the work of these committees.

Over the past 12 months, successful implementation has been achieved in many areas. A selection of highlights are outlined below:

i) Service User Experience in Adult Mental Health (December 2011) - a gap analysis and action plan have been completed, quarterly trustwide monitoring set up through PEDIC patient experience surveys, targets and improvement plans agreed with PCTs and CAGs. This clinical guideline and quality standard was the subject of the morning session at the Trust Conference on 13th November 2012 ‘and key speakers included Dr. Diana Rose (Chair of the NICE guideline Development Group) and Jo Homes (Commissioner) on The Commissioners Perspective. A workshop session was held with table topics relevant to the PCT Patient Experience CQUIN targets that have been highlighted as areas for improvement by Q4 and actions agreed. The morning concluded with Gus Heafield, The Chief Executive, announcing funding - grants of up to £5000, for innovative ideas that could improve our service users’ experience of the care we provide.

ii) Self Harm- Long term management (November 11). To raise awareness of this new NICE guideline and the KHP SHIELD project, a half day conference was held on Thursday 2nd February 2012 at the IOP SGDP Centre, Denmark Hill. A key note lecture was given by Professor Nav Kapur (University of Manchester and Chair of the self-harm guideline development group) in which the most recent research evidence for the management of self-harm was presented. Further dissemination occurred through articles in SLAM e-news bulletin and a workshop at Kings Health Partners Safety Connections Conference in October 2012. The guideline now has a completed gap analysis and a trustwide audit has been undertaken in December 2012. In addition, funding has been made available for the development of a 5-day ‘train the trainer’ course (similar to STORM suicide prevention training) on self harm to SLAM clinical teams.

iii) Managing Acutely Ill patients in Hospital (July 2007). The Modified Early Warning Scores (MEWS) is a scoring method to identify patients who may be deteriorating due to their physical health. It is so successful in improving standards of care for patients that the trust was announced a winner of the Health Service Journal Patient Safety Awards in the mental health category on 4th July 2012. It is the first time this system has been used in a mental health trust and it provides early warnings to enable staff to properly care for patients at the right time and in the right place. Now 93% of patients receive ongoing physical observations. Prior to the introduction of the system this figure was 7% and furthermore, since introduction of the MEWS, inpatient deaths have reduced. More than 1200 members of staff were trained and the system was initially implemented into 57 inpatient areas.
In addition to the HSJ award, on 26th September 2012 the Health Quality Improvement Partnership (HQIP) awarded a contract to SLAM for the multi-site clinical audit ‘Audit of Modified Early Warning Score’ Implementation Across Mental Health Trusts and development of a Failure To Rescue indicator in MH. Starting in September 2012, over a three year period, this will involve training 18 mental health trusts around the country in the use of the MEWS and clinical audit tools to monitor its update and effectiveness.

iv) National Audit of Schizophrenia findings

The RCP National Audit of Schizophrenia fed-back trust level results to SLAM in June 2012 and the results were discussed and action planned at the Psychosis CAG Care Pathways Exec in June 2012. The summary feedback in the trust level report demonstrated that SLAM performed in the middle range/above average on most of the key standard areas with (in common with most trusts) poorer performance on the physical health parameters (e.g. monitoring of glucose, lipids and BP, etc.). The action plan will be reviewed early 2013 to consider the findings and recommendations from the national report published in December 2012.

2. Achievements in 2012 against corporate NICE objectives

Objective 1: Ensure baseline gap analyses and audit/monitoring of the recommendations are completed for all new NICE guidance issued in 2012

Achieved: 2/2 (100%) clinical guidelines, relevant to SLaM services (Infection Control, March 12 and Autism in Adults, June 12), published in 2012, have had a gap analysis completed and have audit/monitoring data ongoing or planned. This is an improvement in timeliness since 2011 where 4/7 (57%) of the guidelines published in 2011 had a gap analysis by the end of Dec 2011.

Objective 2: Review action plans and monitoring for older NICE guidance (pre 2012)

Partially Achieved: 30/46 (65%) of clinical guidelines published January 2004-December 2011 have had their gap analysis/action plans formally updated in 2012. Please see Appendix 1 for further information on which guidelines have had their action plans reviewed and appendix 2 for details on individual guideline action plan/gap analysis updates. One of the 46 relevant clinical guidelines 2004-2011 has still not had a gap analysis returned—‘Autism in children’ published in September 2011. A request has been made for this to be followed up by CAMHS management.

Objective 3: Review the Trust Policy on NICE in line with NHSLA standard requirements

Achieved: The SLaM NICE Trust policy was reviewed (v. 3.2) and minor amendments made to the policy monitoring table and inclusion of the Quality Governance Committee (formerly the Clinical Audit & Effectiveness Committee) were made in August 2012.
Objective 4: Provide regular monitoring of the NICE policy and gaps in compliance, traffic lighting of the individual guidelines to raise awareness of gaps in implementation

**Achieved:** The SLAM NICE guidance Assurance table is included as an appendix to this annual report (see Appendix 1). This assurance table has been a standing agenda item at quarterly QGC meetings in 2012. The 2011 NHSLA NICE policy monitoring report (Dec’ 11) action plan is now completed and was discussed as an agenda item at the 22nd August 2012 Quality Governance Committee. Part of the action plan included revising the template for gap analyses so NICE leads can highlight where lack of funding is leading to low or partial compliance with guideline recommendations. These will be reviewed shortly for inclusion on the clinical risk section of the Trust Assurance Framework.

Objective 5: Work with the Education & Training Department to develop training plans for individual guidelines further

**Achieved:** The Education and Training department has contributed to guideline implementation by ensuring the following NICE guideline related training courses have been made available as currently advertised on the Education and Training internal course bulletin: Delivering the alcohol care pathway in Addictions services; Infection Control; Medicines Management; Needle Exchange and harm reduction; Nutritional Risk in mental healthcare; Awareness and prevention of work related stress; Dual Diagnosis; Better understanding of Personality Disorders – KUF Awareness; MEWs (track and trigger); PSTS; Safeguarding Children; Smoking Cessation; Suicide and Self Harm.

Objective 6: Raise the profile of NICE implementation in SLAM by ensuring high quality assurances are available and clear targets are articulated at PCT core contract meetings.

**Achieved:** There has been further liaison with Croydon PCT Commissioning Managers on NICE reporting arrangements. PCTs are given quarterly updates on newly published clinical guidelines and action undertaken if they are relevant to SLAM as part of the quarterly Quality Core Contract reports.

Objective 7: Ensure integration of NICE action plans into ICPs/CAG structures.

**Partially achieved:** The NICE NHSLA Audit in 2011 found that 12/16 (75%) of gap analysis/audits in the sample had evidence that guideline recommendations had been included in CAG care pathways within last 12 months.

Objective 8: Quality Standards – Ongoing work implementing and monitoring the relevant published quality standards and ensuring SLaM staff contribute to the consultation for those in development in 2012/13.

**Partially achieved.** NICE quality standards are a set of specific, concise statements and associated measures aligned to particular clinical guidelines. There are currently 7 published quality standards relevant to mental health services. In SLAM, the area where most progress has been made in 2012 is with the ‘Service User Experience in Adult Mental Health’ quality standard as described at the beginning of this report. Addictions have recently agreed to review the two quality standards in their area (alcohol and drug use disorders). Further work on implementation of the NICE quality standards in SLAM will be prioritised for 2013.
3. Updates on physical and public health NICE guidance (Natalie Warman)

- **NICE guideline CG50 Managing acutely ill patients in hospital**
  The NICE guideline is embedded across the organisation, with all inpatient areas using the early warning scoring system. Trust wide audits demonstrate improvements in all areas on the use of the recommendations against the guideline. The Maudsley site continues to pilot the a project with Kings’ Acute Assessment Unit to provide support to medical colleagues and there are plans to extend this to GSTT in 2013. The Trust has seen a significant decline in inpatient deaths with only one of these attributed to staff not escalating abnormal physiological observations. The implementation of this guideline won an HSJ Patient Safety Award in July 2012 and the project is being rolled out across 19 mental health providers across the country.

- **CG29 pressure ulcer management**
  Pressure sore prevention and management have been a real priority for MHOAD. The prevalence of pressure sores within the Trust has been higher this year however incidence is very low, as a number of patients have been admitted to our services from other healthcare providers with tissue damage. Care planning and the implementation of the SKIN care bundle have made huge improvements in the early recognition and prevention of skin deterioration. The implementation of the patient safety thermometer and greater emphasis on reporting have been pivotal in making the quality improvement.

- **CG66 type 2 diabetes**
  A recent audit against the NICE guideline was presented to the Physical Healthcare committee in January 2013. Improvements have been made in recording glucose on admission for all patients with 100% compliance against this, however improvements are required in recording lipid profiles. Most patients did have a relevant care plan relating to their diabetes, however more work is required in ensuring that service users with uncontrolled high blood glucose levels are reviewed by an appropriate diabetic review team. The Trust is currently reviewing the current patient information and training resources with KHP and their Diabetes Modernisation Initiative colleagues. In 2013 it is hoped that SLaM will work with the Kings 3dfd project that aims to improve glyceamic control for hard to reach groups.

- **CG40 urinary incontinence and CG49 faecal incontinence**
  The Trust continues to work with Kings’ Nurse Consultant for continence in ensuring that the NICE guidelines are embedded within the Trust. In MHOAD all Essence of Care benchmarks “bladder, bowel and continence care” have been completed by most of the community, continuing care and inpatient teams. Benchmarks are monitored through the MHOA&D Quality Network.

- **Smoking cessation including NICE public health guidance 10**
  The Trusts’ smoke free policy was ratified in July 2012. The Trust by Q3 trained over 33% of eligible staff in level 1 training with the development of a new e-learning package to support the implementation. This means that approximately 50% of clinical staff have been trained to either level 1 or 2 smoking cessation training. The Trust is working will all four borough providers of smoking cessation to support and improve access to interventions for people with a mental illness. BAPD CAG will aim to become completely smoke-free in March 2013.
• Physical activity and the environment PH Guidance 8
  All inpatient service users have access to physical activity referrals via our fitness coordinators, to increase activity levels for those who have limited access to open spaces. The activities leads have developed a draft strategy that supports the NICE guideline.

4. CAG NICE Updates

4.1 Psychosis CAG NICE update: Prof. Philippa Garety, Clinical Director

**NICE Schizophrenia Guideline implementation:**

- The Psychosis CAG Governance structures have been further developed this year.
- The overall governance continues to rest with the Psychosis CAG Care Pathways and Governance Executive which meets monthly.
- The more detailed work implementing NICE Schizophrenia Guideline recommendations is provided by three, key sub-committees of the CAG Executive:
  - Physical Healthcare Committee;
  - Access to Psychological Therapies in Psychosis Project Group (revised in 2012 with new Terms of Reference and Membership; and
  - The newly established Psychosis CAG Clinical Audit Sub-Committee.
- Additionally two project boards have been established this year for the implementation and monitoring of Care Pathways in the CAG – the Lambeth Psychosis Project Board and the Croydon Cross AMH Care Pathway Project Board.
- The Care Pathway implementation has made progress this year with greater clarity on the Care Pathways (including NICE recommendations) and setting measures of quality, clinical effectiveness and fidelity in the delivery of the Care Pathway.
- Physical Healthcare – Specific initiatives include: setting and auditing new standards for Physical Healthcare monitoring, improving the two-way flow of information with GP Practices and CAG-wide policy implementation of ECGs for newly admitted in-patients. A trust-wide survey which compared September 2011 with October 2010 showed an increase in the number of patients offered an ECG (55% in September 2011 vs. 25% in October 2010) and administered an ECG (40% in September 2011 versus 14% in October 2010). We are continuing to work on improving these rates.
- Psychological therapies: the CAG was successful competing to be an IAPT-SMI Demonstration site which commenced in November 2012. This is a national Department of Health Initiative to demonstrate improved access to psychological therapy, addressing barriers and facilitators.
- Carer initiatives in 2012: include developing carer training, carer lead roles in teams and a Training Impact Evaluation Report.
- Working with Pharmacy we have been implementing the recommendations on high dose anti-psychotics. Pharmacy reports that the most recent POMH-UK audit shows the rate of high dose prescribing in the Psychosis CAG acute/PICU services to be 10% compared with 28% in the national sample, thereby achieving our target of less than 20% high dose anti-psychotic prescribing.
4.2 Behavioural and Developmental Psychiatry: NICE implementation update—Dr Jean O’Hara, Clinical Director and Chair of Clinical Governance Committee

The NICE Assurance Table is directly managed by the heads of clinical pathways (Godfried Attafa and Mike Callaghan) who report back to the Clinical Governance Committee. Clinical leads have reviewed the guideline assigned to them to determine relevance and appropriateness across the CAG and within individual service lines as required. Gap analyses and action plans have now been completed for guidelines in existence up to 2011 as reported at the September 2012 Clinical Governance Committee. As new guidance is introduced the process will be continued, with clinicians identified to carry out gap analyses and produce action plans. NICE Guidance on Autism Spectrum Conditions in Adults was introduced in June 2012: so far a gap analysis has been carried out in Service Line 3, Neuro-developmental Disorders, showing full or partial compliance in all relevant areas, with further work planned for the other service lines. Trust leads from within the CAG for NICE guidelines are Dr David Ndewga for Antisocial Personality Disorder, Professor Philip Asherson for Adult ADHD and Dr Janneke Zinkstok for Autism Spectrum Conditions in Adults. Local clinical audits are being encouraged in these areas and a project proposal was received in November 2012 for an audit of Adult ADHD services against NICE guidelines.

4.3 Mental Health of Older Adults Services: NICE implementation update—Sandra Parish, Clinical Effectiveness & Improvement Manager MHOA

The Clinical Academic Group has been in place since October 2010 and clinical governance arrangements remain the same. The Chair of the MHOA&D CAG audit committee attends the SLAM Quality Governance Committee on behalf of the CAG. All MHOA&D CAG Nice audit requests are processed by the Chair and the committee and logged on the CAG Audit database.

CG42 Dementia:
- All Boroughs now have a dedicated memory service. The Lewisham service has been working closely with Bromley Mind and recruited two dementia advisors who will offer specialist advice and support to carers and service users with a new dementia diagnosis.
- The CAG with the support of the Trust Pharmacy Department have been auditing the use of anti psychotic medication for service users with a dementia diagnosis. This work was completed for the Prescribing Observatory for Mental Health-UK (POMH-UK) and is also a CQUIN requirement. We are currently waiting results of the September re-audit.
- The Modernisation Initiative end of life care project finished in December 2011. There has been extensive consultation, feedback and training with staff in relation to the use of advanced care planning and the use of pain tools for service users with a dementia diagnosis. This work has been evaluated and will be available to view on the Modernisation Initiative website.

CG 50 Acutely ill patients in hospital:
- All older adult wards and continuing care units are using modified early warning (MEWS) scores and new track and trigger observation charts. The use of the MEWS charts has been audited by the Trust Clinical Effectiveness Team as well as the Senior Nurse team to ensure compliance. Audits of the use are ongoing throughout the year monitored by the senior nurse team.
CG21 Falls:

- Number and severity of falls continue to be monitored by the senior nurse team and reviewed in the MHOA&D Clinical Governance meeting and Quality Network. Falls are being reviewed by wards as part of the service improvement work of the “productive wards”.
- Falls awareness week in June 2012 was marked by a series of events throughout the CAG and with our health promotion partners.
- The MHOA&D Falls group continues to meet bi monthly and a proposal for a falls review team has been presented and will start in Jan 2013. A multi professional team will review all falls within the acute wards and make recommendations for care and treatment as well as review the falls pathway-this project is initially scheduled for 3 months.
- The CAG co-ordinated a joint workshop/presentation with the Kings Health Partners Falls group at The KHP Patient Safety Conference in October 2012. Ongoing meetings have been useful to share good practice and policy in falls reduction strategies.

CG40 Urinary incontinence and CG49 Faecal incontinence:

- Feedback from National Audit on Continence Care was positive with the Trust scoring the highest out of all Mental Health Trust’s on the organisational audit.
- All essence of care benchmarking “bladder, bowel and continence care” has been completed by most community, continuing care and inpatient teams. Benchmarks are monitored through the MHOA&D Quality Network.

CG29 Pressure ulcer management:

- Pressure ulcers are now reported as incidents on the Datix reporting system at grade C and monitored centrally. Staff are now being encouraged to report at an earlier stage i.e. reporting redness and minor skin tears to alert any difficulties. The focus is now very much on prevention and new protocols have been introduced to inpatient and continuing care units
- Advice on treatment and management of pressure ulcers is available from the Trust physical health care lead and the local modern matron. More staff training has been held on tissue viability to develop leads in the clinical areas
- The CAG physical health care course has included pressure area prevention
- Learning from pressure incidents has contributed significantly to the development of action plan to better equip staff to manage these problems.

CG32 Nutrition support in adults.

- A speech and language therapists (SALT) is employed to assess service users with dysphasia and provide training for staff across the CAG.
- The SALT have been monitoring the lunchtime experience of service users across the clinical areas and have been working closely with staff in the continuing care areas to support good practice at mealtimes.
- The CAG has been working closely with the dietetics department. Audits of menu suitability and food texture have been completed in the continuing care and inpatient units.
- Nutrition training was commissioned for MHOA&D Community Nurses to promote nutritional screening for community clients. Screening is being monitored locally—some improvement has been noted.
CG1 Schizophrenia:
- A new family therapy service has been launched by the psychology department and will be formally evaluated.

CG22 Anxiety and CG23 Depression:
- Redesign of the psychology services in the CAG offers a much wider range of psychological and psychotherapy therapies for all service users.

CG78 Borderline personality disorder:
- Redesign of the psychology services in the CAG will offer a much wider range of psychological therapies for service users with identified BPD diagnosis.

CG25 Violence:
- There is ongoing monitoring of violent incidents through the Quality Network and Clinical Governance.
- Funding has been obtained to develop specialist training for MHOA&D staff for the management of behavioural and psychological symptoms of dementia. A steering group including a carer has been set up to develop the course using best clinical evidence. The training commenced in early 2012 and will be formally evaluated.

CG103 Delirium:
- Guidelines were published in July 2010.
- Formal delirium training has started with the inpatients and liaison teams.
- Delirium has been included on the physical healthcare course which has been running for inpatient and some community staff.

Audit Priorities:
Audit priorities for 2012/2013 were discussed at the MHOA&D clinical governance committee and the CAEC. Audits prioritised and linked to NICE Guidance include: Anti psychotic dementia prescribing; End of life care; Nutrition; and Delirium.

4.4 CAMHS: NICE implementation update
Bruce Clark, CAMHS Clinical Director, Michael Buxton, CAMHS Head of Nursing & Charlotte Connolly CAMHS Clinical Governance Project Officer

Governance
Oversight of NICE Guidelines within CAMHS sits with the monthly CAMHS Exec/Clinical Governance meeting, where NICE Guidance leads are agreed and other issues such as gap analyses are discussed and signed off as required. CAMHS aims to have named ‘leads’ for all CAMHS specific Nice guidance, who are responsible for – amongst other things – ensuring gap analyses are updated, and associate leads for more widely applicable guidance.

Care Pathways
All relevant Nice Guidance is included within the Care Pathways developed within the CAG, to ensure the inclusion of NICE-recommended treatments for each disorder. There remain a number of treatments and disorders that do not have associated NICE guidance and therefore the recommended pathway treatments comprise a mix of NICE guidance treatments and treatments that have a good evidence base but are yet to be assessed or included in NICE guidance. CAMHS is one of the pilot sites for CAMHS IAPT (Increasing
Access to Psychological Therapies), which is focussed on provision of evidence based treatments including CBT and family work.

Current audit and Gap Analysis
The following NICE – focussed audits and gap analyses are underway or have recently been completed: i) OCD - Bruce is working with the adult lead for the gap analysis ii) Depression in Children – audit has been completed and will be shared CAG wide once shared with the team iii) Schizophrenia – CRIS audit planned for this year iv) ADHD – audit underway v) Anxiety audit – planned for this year vi) Antenatal and post natal - Audit is being carried out and results written up vii) Social and emotional in primary and secondary – gap analysis is being updated

Plans for 2012-13
i) Create a quick guide for clinicians to what NICE recommends for clinical presentations/conditions/diagnoses familiar to CAMHS ii) Review the NICE lead roles as required iii) Complete gap analyses as required iv) Identify guidance for future audit

5. Corporate NICE Objectives for 2013/14
- Ensure leads are assigned, gap analyses are completed and audit/monitoring is planned and undertaken for all new relevant clinical guidance published in 2013.
- Continue to oversee and monitor NICE policy implementation in CAGs to ensure care pathways are compliant with NICE guidance and that variance tracking is developed to monitor key NICE recommendations and appropriate leadership and governance structures are in place.
- Quality Standards – Ongoing work implementing and monitoring the relevant published quality standards and ensuring SLaM staff contribute to the consultation for those in development.
- Supporting CAGs to monitor and achieve CQUIN, Sanction and Clinical Commissioning Group (CCG) Outcome Indicator targets in the CCG quality contract which relate to NICE guidance. The CCG Outcomes Indicator Set (formerly known as the Commissioning Outcomes Framework) in 2013/14 are proposals for robust, comparative outcome measures at CCG level and priority has been set on the following areas:
  Domain 1: Preventing people from dying prematurely
  - people with severe mental illness who have received a list of physical health checks
  Domain 2: enhancing quality of life for people with long term conditions
  - Access to community mental health services by people from BME groups
  - Access to psychological therapy services by people from BME groups
  - Recovery following talking therapies (all ages and older than 65)
  - People with dementia prescribed anti-psychotic medication
## Appendix 1: Table of NICE Clinical Guidelines and SLaM Assurances in 2012

### Key
- **Gap Analysis/action plan in 2012**
- **Gap Analysis/action plan in 2011**
- **Gap Analysis pre 2011/not completed**

<table>
<thead>
<tr>
<th>Date Issued</th>
<th>Title</th>
<th>SLaM Lead</th>
<th>Lead CAG</th>
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Date of Board meeting: 22nd January 2013

Name of Report: Finance Report

Heading: Performance & Activity

Author: Tim Greenwood, Mark Nelson
Finance Directorate, BRH

Approved by: Nick Dawe
(name of Exec Member)

Presented by: Nick Dawe

Purpose of the report:
The Finance Report provides an update on the financial position of the Trust as at 31st December 2012 (month 9).

Action required:
To note the contents of the report and the financial pressures and for the members of the Board of Directors to satisfy themselves that actions are appropriate to address them.

Recommendations to the Board:
That the Trust Board of Directors approves the report on the financial position for December 2012.

Relationship with the Assurance Framework (Risks, Controls and Assurance):
Links to the key objective to comply with legislation and regulation in order to achieve the financial targets for the Trust in 2012/13.

Summary of Financial and Legal Implications:
As a Foundation Trust, the Trust’s financial performance is assessed by Monitor against the relevant quarter of the annual plan and against the overall plan. Monitor will adjust the annual risk rating if in-year monitoring shows significant adverse variance to plan which could increase the frequency and intensity of future monitoring. The financial risk rating of the Plan, submitted at the end of May 2012, has been confirmed as a 3.

Equality & Diversity and Public & Patient Involvement Implications:
The importance of the equality and diversity targets must be taken into account in developing the plans to achieve financial balance this year. The financial stability of the Trust is a key foundation for the Trust to ensure it can meet its objectives on equality and diversity in the year and beyond.
1. **Overall Position at Month 9 (see Table 1)**

At the end of month 9 (December 2012), the Trust is reporting a net surplus of £4.2m (£2.9m ahead of the current plan) and EBITDA of £12.2m (£1m above the current plan). There is an ‘operational’ deficit of £2.4m at month 9 offset by the contingency reserve, the release of provisions and other non recurring items. Two year-end forecasts are provided – one a simple extrapolation of the year to date position and one taking account of forecast changes and actions during the remainder of the year.

2. **Variance From Plan (see Tables 1 & 2)**

The table below shows the cumulative variance from the current Annual Plan –

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<th>Service Area</th>
<th>Variance Month 5 £m</th>
<th>Variance Month 6 £m</th>
<th>Variance Month 7 £m</th>
<th>Variance Month 8 £m</th>
<th>Pro Rata Forecast Variance Year End £m</th>
<th>Risk Adjusted Forecast Variance Year End £m</th>
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<td>(1.19)</td>
<td>(1.37)</td>
<td>(1.59)</td>
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<td>1.27</td>
<td>1.29</td>
<td>1.72</td>
</tr>
<tr>
<td>Older Adults &amp; Dementia</td>
<td>(0.53)</td>
<td>(0.54)</td>
<td>(0.51)</td>
<td>(0.51)</td>
<td>(0.41)</td>
<td>(0.55)</td>
</tr>
<tr>
<td>Addictions</td>
<td>(0.05)</td>
<td>0.01</td>
<td>0.04</td>
<td>(0.01)</td>
<td>(0.05)</td>
<td>(0.06)</td>
</tr>
<tr>
<td>Corporate Services</td>
<td>0.22</td>
<td>0.42</td>
<td>0.17</td>
<td>0.28</td>
<td>0.05</td>
<td>0.06</td>
</tr>
<tr>
<td>Corporate Income</td>
<td>0.28</td>
<td>0.24</td>
<td>0.27</td>
<td>0.29</td>
<td>0.68</td>
<td>0.90</td>
</tr>
<tr>
<td><strong>Operational Deficit</strong></td>
<td>(1.16)</td>
<td>(1.21)</td>
<td>(1.60)</td>
<td>(1.95)</td>
<td>(2.38)</td>
<td>(3.17)</td>
</tr>
<tr>
<td>Contingency Reserve</td>
<td>2.06</td>
<td>3.12</td>
<td>3.25</td>
<td>4.05</td>
<td>4.30</td>
<td>5.73</td>
</tr>
<tr>
<td>Provisions Not Utilised</td>
<td>0.40</td>
<td>0.44</td>
<td>0.48</td>
<td>0.71</td>
<td>0.75</td>
<td>1.00</td>
</tr>
<tr>
<td>Investment Fund</td>
<td>0.00</td>
<td>0.00</td>
<td>0.00</td>
<td>0.00</td>
<td>0.00</td>
<td>0.00</td>
</tr>
<tr>
<td>Corporate Other</td>
<td>(0.90)</td>
<td>(1.63)</td>
<td>(1.23)</td>
<td>(1.66)</td>
<td>(1.67)</td>
<td>(2.23)</td>
</tr>
<tr>
<td><strong>EBITDA</strong></td>
<td>0.37</td>
<td>0.72</td>
<td>0.90</td>
<td>1.15</td>
<td>1.00</td>
<td>1.33</td>
</tr>
<tr>
<td>Interest/Depreciation/Profit</td>
<td>1.0</td>
<td>1.31</td>
<td>1.50</td>
<td>1.70</td>
<td>1.90</td>
<td>2.53</td>
</tr>
<tr>
<td><strong>Total Variance</strong></td>
<td>1.37</td>
<td>2.03</td>
<td>2.40</td>
<td>2.85</td>
<td>2.90</td>
<td>3.86</td>
</tr>
</tbody>
</table>

Adverse variance shown as negative numbers

3. **Headlines**

- Overall decrease in the favourable variance from plan with overspends in Psychosis, B&D and Estates driving the position. In addition the Bethlem Triage Ward opened in month 9 and is in deficit whilst discussions continue with Croydon PCT regarding its funding. These overspends have been offset to some extent by CAMHS and MHOA and through the use of both the contingency reserve and release of a bad debt provision against junior doctor income that has now been secured. The overall position is still ahead of Plan at Q3 by £1m equating to a risk rating of 3.

- An overall summary of the position can be seen in the table overleaf -
The position above is being offset by £1.5m of costs associated with several employment tribunals, rental arrears disputes, provision for doubtful SCG and other debts and potential PCT sanctions against not achieving contractual KPIs.

Continued overspends in the main overspending CAGs and Estates –

i) Psychosis (£407k over in month) – mainly driven by continued high acute overspill (26 beds in December)

ii) B&D (£138k over in month) – some non recurring offsets this month have masked the underlying position. The position is expected to deteriorate further next month with activity levels down across BDU, NDS and forensic services whilst forensic external placements continue to remain at unbudgeted levels

iii) Estates (£250k over in the month) – overspends across a number of areas including high agency, energy, maintenance, transport services and impact of centralising previously overspending CAG budgets within Estates

Performance against four of our five main risk areas is detailed below:

<table>
<thead>
<tr>
<th>Area</th>
<th>Mth 4 Variance</th>
<th>Mth 5 Variance</th>
<th>Mth 6 Variance</th>
<th>Mth 7 Variance</th>
<th>Mth 8 Variance</th>
<th>Mth 9 Variance</th>
<th>Total Year To Date £000</th>
</tr>
</thead>
<tbody>
<tr>
<td>CAGs</td>
<td>£000</td>
<td>£000</td>
<td>£000</td>
<td>£000</td>
<td>£000</td>
<td>£000</td>
<td>£000</td>
</tr>
<tr>
<td>Infrastructure Directorates</td>
<td>(223)</td>
<td>292</td>
<td>198</td>
<td>(248)</td>
<td>113</td>
<td>(237)</td>
<td>47</td>
</tr>
<tr>
<td>Non Rec Items</td>
<td>(64)</td>
<td>19</td>
<td>49</td>
<td>42</td>
<td>223</td>
<td>44</td>
<td>754</td>
</tr>
<tr>
<td>Income Provision</td>
<td>(37)</td>
<td>16</td>
<td>40</td>
<td>32</td>
<td>17</td>
<td>391</td>
<td>682</td>
</tr>
<tr>
<td>Use of Contingency</td>
<td>124</td>
<td>435</td>
<td>1,065</td>
<td>129</td>
<td>801</td>
<td>247</td>
<td>4,302</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>70</strong></td>
<td><strong>450</strong></td>
<td><strong>1,064</strong></td>
<td><strong>(217)</strong></td>
<td><strong>673</strong></td>
<td><strong>(135)</strong></td>
<td><strong>2,679</strong></td>
</tr>
</tbody>
</table>

*excluding impact of risk share

Rate of ward nursing variance fell but may be due to seasonal factors – similar pattern to previous years

Acute overspill numbers fell with the opening of Bethlem Triage Ward but higher £ rates paid for placements and backdated 1:1 charges negated the financial impact this month

CPC/C&V income performance fell from previous month. This may be linked to the holiday period as there was reduced activity across a number of areas. Some improvement is expected in January

The risk adjusted forecast position is currently showing a zero variance from Plan (having utilised all contingency reserves) but this may improve if the Trust can exceed its planned CQUIN targets.
4. CAG Issues

The main CAGs of current concern are -

a) Monthly Run Rate

<table>
<thead>
<tr>
<th>CAG</th>
<th>Mth 1 £000</th>
<th>Mth 2 £000</th>
<th>Mth 3 £000</th>
<th>Mth 4 £000</th>
<th>Mth 5 £000</th>
<th>Mth 6 £000</th>
<th>Mth 7 £000</th>
<th>Mth 8 £000</th>
<th>Mth 9 £000</th>
</tr>
</thead>
<tbody>
<tr>
<td>MHOA</td>
<td>(232)</td>
<td>(75)</td>
<td>(52)</td>
<td>(55)</td>
<td>(118)</td>
<td>(10)</td>
<td>(33)</td>
<td>2</td>
<td>90</td>
</tr>
<tr>
<td>Behavioural &amp; Dev</td>
<td>(87)</td>
<td>(113)</td>
<td>(179)</td>
<td>(45)</td>
<td>(205)</td>
<td>(79)</td>
<td>(187)</td>
<td>(274)</td>
<td>(138)</td>
</tr>
<tr>
<td>MAP</td>
<td>(146)</td>
<td>(17)</td>
<td>(23)</td>
<td>(116)</td>
<td>(38)</td>
<td>75</td>
<td>(10)</td>
<td>(142)</td>
<td>(18)</td>
</tr>
</tbody>
</table>

b) Analysis

<table>
<thead>
<tr>
<th>CAG</th>
<th>In Month Variance £000</th>
<th>YTD Variance £000</th>
<th>Comment</th>
</tr>
</thead>
</table>
| Psychosis | (407)                  | (2,001)           | • Acute overspill bed usage fell in month 9 following the opening of the Bethlem Triage Ward and additional investment in key community posts. In December 26 beds were utilised of which 6 were in Croydon and 18 in Lambeth. The acute overspill overspend of £1.4m represents 70% of the total CAG ytd overspend and 77% of the in month overspend.  
  • There continue to be high ward nursing costs in some areas, particularly PICUs. In month 9 Gresham PICU overspent against its nursing budget by £53k due largely to specialising costs above budget.  
  • Restricted controls now in place regarding the use of paliperidone plus the impact of quetiapine coming off patent have slowed down the rate of drug overspend to £16k this month (£294k ytd).  
  • Not achieving CIP plan by £1.4m at month 9 – reduction in placements & overspill, reduction in drugs expend, workforce productivity especially on wards, delay in A&C review & in additional national psychosis beds. |
| MHOA      | 90                     | (416)             | • The costs of ward/unit nursing fell this month and together with central budget phasing and continuing underspends across community services helped to improve the overall position.  
  • Several QIPP schemes which had been delayed are now in place and contributing the improved position. |
| B&D       | (138)                  | (1,307)           | • New Neurodevelopmental Disorder Service continuing to only average 65% occupancy v target of 85% resulting in an income shortfall of £0.37m. Despite occupancy levels not meeting target numbers, the costs of running the Unit are exceeding the budget available. In month 9 pay costs were £50k above budget.  
  • The income/expenditure position on the NDS has been compounded by a
reduction in occupancy on the BDU (now less than 50% in January). Up to month 6 this unit was generating an income surplus of £50k per month but with occupancy falling this is no longer the case.

- Similarly, with an increased forensic CPC target (following Swk PCT pulling out of 5 block beds in August), current occupancy levels continue to be below the new target.
- Forensic ward budgets were re-set in 12/13 but currently overspending by £460k (£373k on nursing).
- Forensic commissioning will transfer to the London Specialist Commissioning Group. From 1/4/13, the use of national tariffs may impact adversely on this service.
- Lambeth forensic placements above plan – were expected to fall later in the year but costs currently escalating partly in preparation for QIPP targets from April 13. Adverse variance increased by £72k in the month (£321k ytd).
- CAG in receipt of £3m of transitional support, occupancy levels are falling or stagnant whilst expenditure budgets are £1.2m overspent. Medium/longer term plans required to close potential gaps in 13/14 and beyond.

<table>
<thead>
<tr>
<th>MAP</th>
<th>18</th>
<th>(433)</th>
</tr>
</thead>
</table>

- Continued improvement in the monthly position largely due to a reduction in the costs of the new AED service coupled with an increase in occupancy levels (68% compared to 53% over the first 6 months).
- The meeting of income targets was also an issue on the Anxiety Disorders Residential Unit (£332k below Plan – up £38k in the month). Discussions have taken place with NCG to agree funding of excess activity up to year end. A verbal agreement has since been given to increase funding.
- Position offset to some extent by on-going underspends in other teams.

## 5. Income Position

The majority of Trust income is in block contracts signed off at the start of the year and payable in monthly instalments making this a stable and secure source of income. This represents approximately £285m or 80% of total income with a further £15m (4%) of operating income not tied to clinical activity (e.g. rental income, charitable donations). However c16% of Trust income is in cost and volume or cost per case contracts where income does vary with clinical activity. This income is therefore less secure and more risky should activity levels drop below plan. The main areas of risk within this are –

- **Overseas Visitors** – overall £154k below target from £1.5m generated year to date. The main area of activity is in Psychosis with £0.84m of overseas income generated at month 9 although this represents a shortfall of £91k against its target position.

- **Cost per Case/Cost and Volume** (see table below)

Currently £749k below target, the position moved adversely by £362k in December. The main changes occurred in Behavioural Disorders Unit where activity has dropped below 50%, the Psychosis Unit, and the Addictions Acute Assessment Unit. The Addictions Unit, in particular, had a poor December with average activity at 43% and as low as 17% on some days. The medium term plan was to increase the number of beds on this Unit with work flowing from acute hospital A&E departments that would enable sufficient income to make it financially viable. However in the light of recent activity numbers, this plan is being reviewed.
The table below illustrates the overall performance and performance by CAG.

<table>
<thead>
<tr>
<th>CAG</th>
<th>Income Target At Month 9 £'000</th>
<th>Actual Invoiced At Month 9 £'000</th>
<th>Surplus/Deficit(-) At Month 9 £'000</th>
<th>Surplus/Deficit(-) Last Month £'000</th>
</tr>
</thead>
<tbody>
<tr>
<td>Psychosis</td>
<td>2,764</td>
<td>2,919</td>
<td>155</td>
<td>202</td>
</tr>
<tr>
<td>Behavioural &amp; Dev</td>
<td>8,686</td>
<td>8,463</td>
<td>(223)</td>
<td>(163)</td>
</tr>
<tr>
<td>Psychological Med</td>
<td>11,624</td>
<td>12,014</td>
<td>389</td>
<td>445</td>
</tr>
<tr>
<td>Mood, Anxiety &amp; PD</td>
<td>5,921</td>
<td>4,942</td>
<td>(978)</td>
<td>(888)</td>
</tr>
<tr>
<td>CAMHS</td>
<td>14,963</td>
<td>15,084</td>
<td>121</td>
<td>149</td>
</tr>
<tr>
<td>Addictions</td>
<td>1,659</td>
<td>1,446</td>
<td>(213)</td>
<td>(132)</td>
</tr>
<tr>
<td><strong>TOTAL</strong></td>
<td><strong>45,617</strong></td>
<td><strong>44,868</strong></td>
<td><strong>(749)</strong></td>
<td><strong>(387)</strong></td>
</tr>
</tbody>
</table>

The graph below illustrates the overall performance and performance by CAG.

For the wards/units of most concern, Table 3 shows the actual bed occupancy position versus target occupancy for the first 9 months of 2012/13.

6. **Key Financial Risk Areas**

The following 4 areas, together with the variable income position outlined above, have been helping to drive the overall financial position of the Trust -

i) **Acute/PICU Overspill**

Overall, 26 beds were used outside the Trust in December, a reduction of 10 compared to the previous month. This included 18 beds from Lambeth and 6 from Croydon. The reduction follows the opening of the Bethlem Triage ward in December and the employment of additional key workers in Lambeth. The total cost of overspill after 9 months is £2.6m and makes up 70% of the Psychosis overspend variance. Discussions continue with Croydon PCT regarding the funding of the new Triage Ward.
ii) Ward Nursing Costs (Tables 4 - 5)

At month 9 ward nursing costs were overspent by £2.6m (an increase of £150k in the month). This represents a reduction in the rate of overspend from previous months but may reflect the seasonal nature of the period as reductions occurred at a similar point last year with subsequent increases then taking place in the following month(s).

The top 10 wards highlighted in Table 5 make up 70% of the variance. Of the 10 current wards, half sit within the MHOA CAG. However, progress has been made within this CAG and the ward/unit nursing positions have been improving over the last 3 months.

iii) Forensic Placements

All 3 boroughs are covered by risk share agreements with the PCTs. The position has stabilised in Lewisham with placements being made at Heather Close. The overspend in Lambeth has accelerated over the last 3 months and is, in part, due to QIPP requirements to reduce the number of forensic beds from 1/4/13.
iv) Cost Improvement Programme (CIP) & PCT Disinvestment

a) CIP (Table 6)

The Trust is currently reporting an overall adverse variance of £3.4m (23%) against its original plan of £14.9m at month 9. At month 9, 70% of the savings plan had been phased into the year to date position.

The main areas of variance lie in Psychosis, B&D, MAP and Estates and are largely due to the plans in place not delivering as expected plus some slippage. Some of these shortfalls are associated with some of the financial risks described previously such as income targets not being met, increased use of paliperidone offsetting other drug savings and nursing costs, forensic placements and acute overspill costs not reducing in line with plan.

There are 213 savings schemes within the overall CIP programme. Approximately 7% of these schemes account for 80% of the variance. The main areas of variance are highlighted in Table 6.

b) PCT QIPP (disinvestment) - Table 7

There is currently a shortfall of £1.3m against the PCT QIPP target attributable to SLaM. This shortfall is largely in Psychosis and relates to targets not being met from reductions in Lewisham forensic placements, Lambeth rehab placements and Southwark PICU beds.

Further reductions of £1.2m are due to take place in both Lambeth and Southwark over the final quarter with changes to the provision of acute beds. However, Lambeth is currently running with 18 acute overspill beds and plans to change bed numbers in Southwark have slipped. These schemes will not deliver in 2012/13 and the current adverse variance will therefore accelerate over the final quarter to an estimated forecast gap of £3m.

Within the current position, no allowance has been taken of the risk shares that are in place to help mitigate the impact of delays in realising QIPP savings. Lambeth and Southwark PCTs are each holding a £0.6m risk reserve for any such eventuality. In Lewisham,
slippage on the reprovision of Granville Park has been recognised by the PCT and mitigated by additional PCT income.

7. Summary

The overall financial performance of the Trust remains a concern with actual levels of activity considerably exceeding contractually funded levels of activity and with several cost improvement and income generation targets not met. If not addressed these issues become a £5m burden on next year’s plan.

The risk adjusted forecast position is currently showing a zero variance from Plan (having utilised all contingency reserves and assuming the Trust is able to access the PCT risk reserves being held to provide cover against slippage in achievement of QIPP).

To ensure this position is delivered the following key actions are required:

That CAGs and Corporate Services deliver an out-turn no worse than currently forecast and in particular that overspill numbers continue to drop and that spending on agency nursing staff is reduced and that spending on general agency staff is all but eliminated.

That outstanding cost improvement proposals are delivered and that some further progress is made with hitting income generation targets for new services.

That 2012/13 general and CQUIN performance is improved to reduce the likelihood of any sanctions (contract value reductions) being imposed or expected CQUIN income lost.

That discussions are concluded with PCTs on the release of funding to cover QIPP under performance issues and activity over performance

That the discussions on funding the Croydon triage ward and other community investments are concluded successfully.

The position could further improve:

If demand levels, particularly for inpatient services, fall. This is unlikely based on previous year’s activity trends.

If CQUIN performance improves beyond expectation and if all contract targets are met. This is possible and currently effort is being put into delivering key CQUIN targets in full, with some limited investment if necessary.

Other issues of note

The balance sheet of the Trust remains strong, with a good cash-flow position and minimal concerns regarding bad and doubtful debt.
TRUST BOARD - SUMMARY REPORT

Date of Board meeting: 22nd January 2013

Name of Report: Chief Executive's report

Heading: - (Strategy, Quality, Performance & Activity, Governance, Information) Governance

Author(s): Paul Mitchell, Trust Board Secretary

Approved by (name of Executive member): Gus Heafield, Acting Chief Executive

Presented by: Gus Heafield, Acting Chief Executive

Purpose of the report:
To inform the Board of significant issues arising from Trust Executive meetings, Performance Management meetings, an update on information governance issues, the local health economy and nationally in the NHS and Social Care.

Action required:
To discuss items of concern and where necessary initiate additional assurance action.

Recommendations to the Board:
To note the report.

Relationship with the Assurance Framework (Risks, Controls, and Assurance):
The report highlights issues relating to the Assurance Framework arising from Trust Executive meetings, Performance Management meetings, the local health economy and nationally in the NHS and Social Care.

Summary of Financial and Legal Implications:
The report highlights any financial and legal Implications arising from Trust Executive meetings, Performance Management meetings, the local health economy and nationally in the NHS and Social Care.

Equality & Diversity and Public & Patient Involvement Implications:
The report highlights equality & diversity issues arising from Trust Executive meetings, Performance Management meetings, the local health economy and nationally in the NHS and Social Care.
1. National issues

1. NHS Commissioning Board sets out planning guidance for first year
The NHS Commissioning Board has published its planning guidance for NHS commissioners, called ‘Everyone Counts: Planning for Patients 2013/14’. The guidance covers a set of outcomes against which to measure improvements. It outlines five offers – moves toward seven-day a week working for routine NHS services, greater transparency and choice for patients, more patient participation, better data to support the drive to improve services, and higher standards and safer care.

Also published are financial allocations to CCGs, and advice for every CCG and local authority on measuring outcomes, which will support and inform their planning and strategy development.

Personal health budgets
Care and Support Minister, Norman Lamb, announced the rollout of personal health budgets following the end of a three-year pilot, and publication of the independent evaluation. This showed that people’s quality of life improved, and hospital admissions decreased. Rollout will start with people who are receiving NHS continuing care, having the right to ask for a budget by April 2014. Future CCGs can offer them to other people who clinicians feel may benefit from the additional flexibility and control. From April 2013, responsibility for personal health budgets will transfer to the NHS Commissioning Board.

Contractual duty of candour - standing rule regulation
Ministers have announced the creation of a standing rule regulation that requires the NHS Commissioning Board to insert a contractual duty of candour into the NHS standard contract. This requires relevant organisations to disclose to patients or their representatives when they have been involved in a patient safety incident, building on the principles of the National Patient Safety Agency’s Being Open policy.

Winterbourne View report
The Government has published its final review into the criminal abuse that took place at Winterbourne View Hospital. This sets out a programme of change to rapidly improve the standard of care for vulnerable people across the health and care system, with specific recommendations for healthcare providers.

These include, reviewing all current placements by June 2013, so everyone in hospital inappropriately will move to community-based support as quickly as possible, and no later than June 2014. A concordat signed by over 50 stakeholder organisations has also been released.

A further report on progress to implement these recommendations will be published by December 2013.

2. Trust issues

Ministerial visit
Health Minister, Norman Lamb, visited Maudsley Hospital to meet service users, carers and staff who will benefit from better access to talking therapies. He came to see a new scheme
which could improve the care and treatment of people with severe mental illnesses as it was officially launched.

South London and Maudsley NHS Foundation Trust is one of only two Trusts in the country which has just been awarded funding from the Department of Health to increase access to psychological therapies for people with psychosis. Rates of psychosis are extremely high in South London - with the borough of Lambeth known for having one of the highest recorded rates of psychosis in the world.

The new scheme will mean patients with the most severe mental illness and personality disorders will be offered appropriate therapies most suited to their illness.

**Congratulations**
Prof Simon Wessely, Academic lead for the Psychological Medicine CAG and head of the department of psychological medicine at the Institute of Psychiatry, King’s College London, has been awarded a knighthood in the New Year’s Honours List. He is acknowledged as a leading researcher into the mental health of military personnel.

Janet Treasure, Professor of Psychiatry and Director of the Eating Disorders Unit at SLaM, has been awarded an Order of the British Empire (OBE) in the New Year’s Honours List for services to people with eating disorders.

**South London Healthcare**
King’s Health Partners has responded to the draft report by the Trust Special Administrator into the future of South London Healthcare NHS Trust and services in South East London.

In the letter King’s Health Partners acknowledges the need to reach a clear and sustainable future that delivers high quality, affordable healthcare as soon as possible but also highlight that the TSA’s draft report fails to reflect the potential benefits of the Academic Health Science Centre approach and does not sufficiently acknowledge considerations around mental health.

### 3. Chief Executive Performance Management Review

Key items discussed at the CE PMR in January were:

**Themed review: RESEARCH**
- Recruitment to NIHR portfolio studies
- Recruitment to non-portfolio studies. CAGs agreed to collect this data at the August 2012 CEO PMR.
- Progress with ‘consent for consent’
- Delivery of Clinical and Academic Excellence – KHP Strategic Objective

**Business Planning progress**
The focus of this discussion was about the support that CAGs would need to delivery their business plan objectives and savings plans. CAGs were specifically asked about the support they will need from infrastructure directorates.

**Gus Heafield**
**Acting Chief Executive**
**January 2013**
<table>
<thead>
<tr>
<th><strong>Purpose of the report:</strong></th>
<th>To update the Board on the current areas of Members’ Council activity.</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Action required:</strong></td>
<td>To note.</td>
</tr>
<tr>
<td><strong>Recommendations to the Board:</strong></td>
<td>To note.</td>
</tr>
<tr>
<td><strong>Relationship with the Assurance Framework (Risks, Controls and Assurance):</strong></td>
<td>The Members’ Council is an integral component of the Trust’s Constitution as a Foundation Trust.</td>
</tr>
<tr>
<td><strong>Summary of Financial and Legal Implications:</strong></td>
<td>Budgetary provision has been made to support the activities of the Members’ Council.</td>
</tr>
<tr>
<td><strong>Equality &amp; Diversity and Public &amp; Patient Involvement Implications:</strong></td>
<td>The Members’ Council has a responsibility to ensure that the Trust’s membership is representative of the local populations in terms of diversity and that all members, including those from the patient &amp; public constituencies, are fully involved.</td>
</tr>
</tbody>
</table>
1. South London Healthcare Trust

King’s Health Partners has responded to the draft report by the Trust Special Administrator into the future of South London Healthcare NHS Trust and services in South East London.

In the letter King’s Health Partners acknowledges the need to reach a clear and sustainable future that delivers high quality, affordable healthcare as soon as possible but also highlight that the TSA’s draft report fails to reflect the potential benefits of the Academic Health Science Centre approach and does not sufficiently acknowledge considerations around mental health.

2. Annual plan development

As previously reported, a programme of meetings was held in each of the four Boroughs so as to involve the wider membership in the development of the next annual plan. All the information provided is being collated and will help inform the development of the Trust’s annual plan. A presentation was made to Members’ Council meeting on Thursday, 13th December 2012. A summary of the main findings were as follows:

Feedback – general provision of care
  • Early intervention and prevention
  • More therapies, less medication
Feedback – treatment
  • Speedier access
  • Respect confidentiality
  • Be taken seriously
  • Staff awareness of cultural, linguistic and ability needs
Feedback – in patients
  • More structured day
  • More activities
  • Keep appointments
Feedback – discharge
  • Advice and information
  • Continuity of care
  • Support for personalisation
Practical support
  • Legal help, carers awareness of powers of attorney
  • Support networks and self help groups
  • Information about local voluntary services
  • Peer support
  • Respite care
Working with GPs
  • Better education and understanding about mental health
  • Closer working between SLaM and GPs
Saving money

• Fewer buildings
• Review administrative and management costs
• Use opportunities from KHP for closer integration of services and departments

Lessons learned

• More advance notice of meetings
• Use of networks is key to ensuring good attendance
• A more informal conversational style works best

Repeat in 2013
• Definitely

3. Joint Governors

The final 2012 joint governors meeting of the three Foundation Trusts within King’s Health Partners was held on Wednesday, 12th December. The main item for discussion was the response to the the draft report by the Trust Special Administrator into the future of South London Healthcare NHS Trust and services in South East London.

4. Joint meeting with the Board of Directors

The joint meeting between the Members Council and the Board of Directors will be taking place on Friday, 18th January. This will follow the format used in previous years of a review of activity over the past year plus a look forward to the year ahead as a means of producing a work programme.

5. Re-appointment of a Non Executive Director

The Members’ Council agreed the recommendation from the Nominations Committee for the re-appointment of Ms Harriet Hall as a Non Executive Director on the SLaM Board of Directors for an initial period of 12 months, to be reviewed by the Chair during the course of the year.

Paul Mitchell
Trust Secretary
January 2013
**Purpose of the report:**
To inform the Board of Directors on the progress made on the development of SLaM/IoP Mental Health Clinical Academic Groups and the wider developments across King’s Health Partners

**Action required:**
The Board of Directors is asked to approve the verbal report.

**Recommendations to the Board:**
The verbal report is for information.

**Relationship with the Assurance Framework (Risks, Controls and Assurance):**
One of the purposes of the King’s Health Partners Executive is to ensure that the impact of the development of King’s Health Partners is positive with regard to each constituent organisation’s risks and controls

**Summary of Financial and Legal Implications:**
The current report does not contain any legal implications. As the work develops, any significant legal or financial implications will be brought to the Board of Directors for consideration. There are resource requirements to ensure that the Trust contributes to delivery within the King’s Health Partners Strategic Framework 2010-2014

**Equality & Diversity and Public & Patient Involvement Implications:**
A key purpose of King’s Health Partners is to improve the health and wellbeing of local people. In developing their strategies, the CAGs are specifically required to state how they will address the health inequalities reflected in the “heat map”. This of necessity requires that service users and their carers are actively involved in their own care and the developments within services. It also requires that no service user receives less favourable services or outcomes as a result of their ethnicity, gender, disability, sexuality, faith or age.
### Purpose of the report:

To present the annual report on serious incidents and patient safety for 2011/2012.

### Action required:

To read the report.

### Recommendations to the Board:

The report is received.

### Relationship with the Assurance Framework (Risks, Controls and Assurance):

Many of the risks logged on both local risk registers and the quality section of the Board Assurance Framework are identified through the incident reporting and investigation process.

### Summary of Financial and Legal Implications:

There are no immediate financial or legal implications.

### Equality & Diversity and Public & Patient Involvement Implications:

There are no immediate Equality & Diversity or Public & Patient Involvement implications.
Serious Incidents and Patient Safety
April 2011 – March 2012

Annual Report to the Board of Directors
## Index

<table>
<thead>
<tr>
<th>Section</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Introduction</td>
<td>3</td>
</tr>
<tr>
<td>2. Reporting incidents and serious incidents</td>
<td>3</td>
</tr>
<tr>
<td>3. Serious incidents by number</td>
<td>4</td>
</tr>
<tr>
<td>4. Serious incidents by severity</td>
<td>4</td>
</tr>
<tr>
<td>5. Analysis of main serious incident categories for 2010/11</td>
<td>5</td>
</tr>
<tr>
<td>6. Trust wide improvements arising from serious incident investigations</td>
<td>14</td>
</tr>
<tr>
<td>7. CAG structured investigations, reports and panels</td>
<td>15</td>
</tr>
<tr>
<td>8. Trust investigation facilitator activity</td>
<td>16</td>
</tr>
<tr>
<td>9. Trust serious incident committee</td>
<td>18</td>
</tr>
<tr>
<td>10. Independent investigations commissioned under HSG 94(27)</td>
<td>18</td>
</tr>
<tr>
<td>11. Coroners Rule 43</td>
<td>19</td>
</tr>
<tr>
<td>12. Learning lessons reports and patient safety bulletins</td>
<td>19</td>
</tr>
<tr>
<td>13. Presentations and training</td>
<td>19</td>
</tr>
<tr>
<td>14. Investigations and inquiries into outside organisations</td>
<td>19</td>
</tr>
<tr>
<td>15. Reports from external agencies</td>
<td>20</td>
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1. **Introduction**

This report gives an overview of serious incidents reported by Trust staff between April 2011 and March 2012 (hereafter referred to as 2011/12). Data on the number and severity of the serious incidents is summarised. The report gives examples of themes identified by investigations into serious incidents, examples of the lessons learnt in response to the findings of the investigations and examples of the risk management responses taken by the trust.

Serious incidents are defined as reported incidents graded as A, B or C severity using the Trust Risk Assessment Tool. Severity is usually determined by the outcome of an incident in terms of harm to the people involved, for example death or injury. Other outcomes taken into account, but less commonly used, are:
- service disruption
- breaches of legal requirements
- financial implications

All serious incidents are recorded on the Datix information system. The Datix database is the source of the data for the report.

The report covers the period following the reconfiguration of Trust clinical services from borough-based services to Clinical Academic Groups (CAGs). For this reason it is difficult to make specific comparisons with previous serious incident data which was historically recorded by borough rather than CAG.

2. **Reporting incidents and serious incidents**

Datix is now used to report all Trust incidents. The benefits of Datix include:
- Ease of use and accessibility
- Legible incident reports
- Instant notifications of incidents to those who need to know
- Mandatory grading of certain incidents
- Opportunities for teams to review themes and trends, for example in the eating disorders inpatient service have recently used the system to help understand particular training needs for the staff team

3. **Serious incidents by number**

There were 2702 serious incidents reported during 2011/12. A comparison table of previous year figures is shown in table one below.

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<thead>
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<th></th>
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</thead>
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<td>Totals</td>
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<td>1756</td>
<td>1961</td>
<td>2334</td>
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</table>

Table one: Serious incidents reported between 2007/08 and 2011/12

4. **Serious incidents by severity**

Serious incidents as a percentage of all reported incidents increased slightly to 22.5% during 2010/11. A comparison of all incidents reported during the period 2006-2012 by severity grading is shown in table two below.
The use of Datixweb is thought to be a significant factor in the ongoing increase of serious incident reports during the past six years. This is due to the:

- Increased awareness of incident reporting among services who traditionally rarely reported incidents for example estates and facilities staff
- Datixweb training which has reminded staff of the importance of incident reporting
- Ease of reporting – all staff with access to a trust computer are able to report an incident
- Involvement of ward staff in grading the incident and the subsequent changes in grading behaviour when reporting incidents on-line

Other mental health trusts have also reported similar increases in serious incident reporting as electronic incident reporting systems have become more accessible and user friendly.

The ongoing increase in reported C grade serious incidents can be attributed to:

- Improved incident reporting thresholds across the Trust. This has been a response to the introduction of CAGs for example the Psychosis CAG have introduced systematic reporting and response systems to incidents of absconding and absence and the Behavioural and Developmental Psychiatry (B&DP) CAG in particular have worked towards ensuring the systematic reporting of adult safeguarding incidents.
- Changes in grading behaviour when reporting incidents on-line. The increase in C grade serious incidents has been proportionate to the roll out of Datixweb incident reporting. Staff who report incidents on-line are responsible for grading them. There is likelihood that staff will grade their incidents higher than when reporting using paper incident forms. Furthermore, Datix incident reports are immediately received by a wide readership via systematic email alerts. This means there is an increased possibility of incidents being upgraded.
- Changes in grading protocols. These changes help to target certain types of incidents for risk management purposes, for example staff now grade the following types of incidents at a minimum C rather than D or E grade:
  - absence and absconding incidents (in line with updated absence and absconding policies and procedures)
  - medication incidents
  - allegations of sexual abuse
  - child safeguarding incidents
  - adult safeguarding incidents
  - RIDDOR (HSE) reportable incidents
  - unexplained bruising of Mental Health of Older Adults & Dementia (MHOA&D) patients
- Changes to reporting policy. In line with recent revisions of the Incidents Policy C grade incidents do not always require a fact-finding report. This may have led to staff more likely and correctly reporting an incident as a serious incident.
5. Main serious incident categories

This section includes:
- An analysis of the main serious incident categories
- Examples of actions taken and improvements made to minimise the risk of recurrence of these serious incidents

5.1 Aggression and violence by patients

Patient aggression accounts for around half of all reported Trust incidents. Most aggression is directed by patients towards staff although patients frequently assault other patients and occasionally visitors. There was an increase in serious incident reports of violence and aggression during 2011/12: reports compared to 570 reported in 2010/11. There were increases noted in reports made in the following categories:
- Violence and aggression committed by patients in the community
- Verbal abuse by patients towards staff

It is also noted that there were spikes in certain areas often as a result of the behaviour of challenging individuals.

During 2010/11, the Trust built on previous measures to reduce levels of aggression. These measures included:
- Year-on-year targets put in place to reduce violence and aggression as part of the Magnet Recognition Programme.
- Building on previous year increases in patient sanctions and convictions following aggressive acts.
- Quarterly serious incident reports and patient safety bulletins are published and circulated to CAGs. The reports and bulletins give a detailed breakdown of incidents by type and location enabling the prompt identification of trends and pressure points.
- There is now full CAG representation at the prevention and management of violence and aggression meeting. This bi-monthly meeting considers and works towards implementing initiatives to reduce violence and aggression.
- CAG services and the Patient Safety Team have compiled a number of reports on violence to assist teams in understanding trends in violence and aggression.
- The mobile police custody unit attending the Bethlem Royal Hospital site on a monthly basis.
- There is a police officer presence on the Maudsley Hospital site.
- The Bethlem Royal Hospital has a team of police identified to work with the hospital.

Examples of planned actions and improvements to minimise the risk of recurrence of violence and aggression during 2012/13 include:
- Roll out of the ASCOM alarm system.
- CAGs establishing violence and aggression reduction working groups.
- Improvements in the interface with the police are set to continue with meetings planned between senior trust staff and borough commanders.

5.2 Fire and arson

Thirty-two serious fire incidents were reported during 2010/11 compared to 27 in 2009/10 and 34 in 2008/9. These reports include incidents reported in inpatient areas and in the community for example fires in the homes of patients.
Examples of actions taken and improvements made to minimise the risk of recurrence of fire and arson include:

- A structured investigation was undertaken into a serious incident of arson which happened at River House in April 2010. The recommendations following the investigation were rolled out across the River House estate and helped inform practice elsewhere in the Trust.
- The findings and recommendations contained in an NHS London commissioned report into the management of five hospital fires between January 2008 and February 2009 were subjected to ongoing review and gap analysis to help ensure that lessons were learnt and improvements made.
- Reported fire incidents are now routinely reviewed at the Trust Risk Management Committee.

Examples of planned actions and improvements to minimise the risk of recurrence of fire and arson during 2010/11 (from Ron Moody Health and Safety Risk Manager):

- There will be greater emphasis on the need for wards to carry out regular fire evacuation drills. Fire Safety Advisors will be available to observe and offer advice during these drills.
- It will become compulsory for all staff to complete annual fire safety training including those who attend the bi-annual warden training. Staff will be able to alternate annually between face-to-face sessions and e-learning.
- A review will be undertaken of the frequency of audits for non-sleeping risk properties and administrative areas will take place. It is recommended that these areas are audited bi-annually as opposed to annually.
- Each property/ward will be issued with an up-to-date Fire Logbook and a Maintenance Fire Logbook as well as guidance on obtaining and updating all required information.

5.3 Reports of homicide by patients

Four alleged homicides involving current or discharged Trust patients were reported during 2010/11. All homicides involving current or discharged Trust patients are notified to the relevant Primary care Trust and to NHS London. Serious incidents of this kind are also subject to a structured investigation and Board Level Inquiry.

Examples of actions taken and improvements made to minimise the risk of recurrence of homicide

- All incidents of suspected or actual homicide are investigated by a suitably qualified and experienced investigation team external to the service area. A Trust Investigation Facilitator is always involved in such investigations and a Board Level Inquiry commissioned.
- The Patient Safety Team have successfully worked towards ensuring that a Board Level Inquiry is undertaken as soon as possible after the completion of the Structured Investigation. This helps to ensure prompt and consistent learning.
- The Trust Investigation Facilitators have developed close relationships with police investigating suspected homicides. This ensures absolute certainty over what aspects of the person’s care and treatment can be investigated without compromising any police investigations.
- The Patient Safety Team are working increasingly closely with the Strategic Health Authority (SHA), NHS London, to ensure that where necessary the SHA commission a proportionate independent investigation under HSG 94(27) as soon as possible after a conviction is made. This helps reduce the delay in commissioning and ensures prompt investigation and learning.
• Lessons learnt from internal and independent investigations into the care and treatment of patients convicted of homicide are routinely raised at the Trust Clinical Risk Committee and in Learning Lessons reports.
• Lessons learnt from independent investigations into the care and treatment of patients convicted of homicide from other Trusts have been reviewed at the Trust Clinical Risk Committee and raised in Learning Lessons reports. These include:
  o A summary of the independent investigation commissioned by NHS East of England into the care and treatment of patient Tennyson Obhi. This report was reviewed at the February 2011 Clinical Risk Committee and shared with the CAGs in various forums
• The finding and recommendations outlined in the Annual Report of the National Confidential Inquiry into Suicide and Homicide by People with Mental Illness was subjected to review at the Trust Clinical Risk Committee in September 2010.

5.4 Medication errors

Two hundred and thirty six medication serious incidents were reported in 2010/11 compared to 259 in 2009/10 and 388 in 2008/9. Medication serious incidents are by their nature broad and include medication related incidents at the point of prescribing, dispensing and administration (including patient self-administration).

Since January 2006 all reported medication incidents are graded as a minimum C and fast tracked for data input and investigation. In all such cases a fact-finding report is required. A monthly schedule of reports was compiled and forwarded to relevant Nurse Advisors and where necessary the pharmacy department for review and follow-up. The majority of medication incidents are now closed upon receipt of fact finding reports, as these are generally well completed and provide quick and valuable details of lessons learned and recommendations for reducing further errors.

Examples of actions taken and improvements made to minimise the risk of recurrence of medication errors
• The medication management competency-training programme has been in place in all clinical services since 2007. The competency programme covers all the key medication administration themes seen in incident reports. When competency issues come to light through fact finding reports, nurses have to complete competency training again before they can administer medication.
• Where prescribing problems were apparent, the incident data is used to inform quarterly prescribing bulletins.
• A Medication Errors Committee, a sub-committee of the Medicines Management Committee has been convened. The committee is chaired by the Principal Pharmacist and attended by nurse advisors, a medical representative and the Assistant Director of Patient Safety. Themes and trends are explored and local and trust wide actions are taken to help reduce the frequency of medication errors.
• Nurse advisors automatically receive Datixweb notifications of medication error incidents which happen in their areas as and when they are reported.
• Monthly medicines management bulletins are circulated. These highlight errors and good practice.
• The quarterly Learning Lessons reports identify medication error themes and trends and any lessons learnt in response to those errors.
• Medical staff, mainly consultants, have been encouraged to arrange to receive Datixweb alerts for their wards and teams. There has been a good take-up of this initiative.
• Diabetic management, particularly the administration of insulin, will feature more prominently in Trust medicines management training.

5.5 Patient falls

There were 632 incidents of falls reported during 2010/11 of which 46 were graded as serious incidents. This compares to the 2009/10 figure of 705 incidents of falls (of which 37 were graded as serious incidents) and the 2008/9 figure of 770 incidents reported (of which 42 were graded as serious incidents).

The majority of patient falls are reported by the MHOA&D CAG i.e. 37 of the 46 serious incidents reported during 2010/11. The majority of reported falls happened in inpatient settings but falls were also reported in patients homes and public places.

Examples of actions taken and improvements made during 2010/11 to minimise the risk of recurrence of falls
• All reports are reviewed by the relevant MHOA&D modern matron and a review of falls incidents is a standing agenda item of the MHOA&D CAG Patient Safety Committee.
• MHOA&D CAG reviewed and updated the CAG Falls Protocol.
• A falls network has been convened and six-monthly falls review meetings with all professional groups are undertaken.
• Joint working arrangements have been put in place with physiotherapy and exercise instructors to help in the prevention of patient falls.
• MHOA&D CAG participated in the National Falls Awareness Week during June 2010. The focus was on the importance of strength and balance among those who are liable to falls.
• Reported falls are reviewed with the Occupational Therapy Assistive Technology Lead and there is to be further consideration of the potential for assistive technology in the management and reduction of falls.
• MHOA&D CAG have signed up to the National Audit of Falls and Bone Health (September 2010).
• The MHOA&D Nursing Council have set a target to reduce severe falls incidents falls by 50% until 2014 in the continuing care wards and acute inpatient units.

5.6 Self-harm

There were 182 serious incidents (560 incidents in total) of serious self-harm during 2010/11 compared to 113 serious incidents (406 incidents in total) reported in 2009/10. These numbers exclude suicide and attempted suicide. Self-harm was largely carried out by a small number of patients in certain wards rather than a broad group of patients in a large number of wards. For example, the Crisis Recovery Unit and the children and adolescent wards routinely report high numbers of incidents and serious incidents of self-harm among their residents and patients. Furthermore, 20010/11 saw a small number of patients on acute admission wards who were involved in a high number of incidents of self-harm.

Examples of actions taken and improvements made to minimise the risk of recurrence of self-harm
• Self-harm is often patient and circumstance dependent and therefore not a category which can be subject to systematic reduction measures.
• Agreements have been put in place between the Crisis Recovery Unit and the Patient Safety Team to ensure the correct threshold of incident grading and identification of the
necessary actions to be taken. These arrangements were ratified at the Trust Clinical Risk Committee in September 2010.

- Staff worked closely to help ensure that measures were in place to minimise the risk of self-harm by a challenging inpatient at Bethlem Royal Hospital. The patient had a history of hurting herself while on leave in the grounds of the hospital. While such incidents were not entirely prevented they were minimised in response to staff working together.
- The Crisis Recovery Unit staff provide advice to colleagues in acute admission wards to assist them in the safe management of patients prone to committing self-harm.

### 5.7 Sexual assault

During 2010/11 there were 20 actual and alleged serious incidents reported of sexual assault (41 incidents in total). This compares to 16 serious incidents reported during 2009/10 (25 incidents in total). These reports included incidents in the community (the majority) and in inpatient services or in the grounds. The types of incidents included unwanted or inappropriate touching and exposure and incidents where the victim and perpetrator were of the same sex. All allegations of sexual assault were reported to service managers and referred to safeguarding children or adult safeguarding procedures where the patient was a victim. Where allegations were made about staff then appropriate actions were taken. These actions included suspending or removing staff from their area of work and investigating the matter in accordance with serious incident and human resources procedures. A report was submitted to the relevant professional body/organisation where necessary.

Examples of actions taken and improvements made to minimise the risk of recurrence of sexual assault during 2010/11:

- The Bethlem Royal Hospital (BRH) Site Co-ordinator has continued to consolidate previous initiatives to ensure shared awareness of the site and an awareness of any particularly vulnerable and high-risk patients.
- A synopsis report of incidents of sexual assault in the grounds of the Bethlem Royal Hospital is reviewed at the BRH Site Meeting. Although the numbers are small, this helps to ensure that improvements are made to minimise the risk of further incidents for example making a case for improved lighting.
- Adult safeguarding training is now mandatory for all staff. This assists staff in identifying and responding appropriately to adult safeguarding incidents.
- In line with the measures outlined in Section 5.1 above, there is now an increased possibility that patients and others will be cautioned/prosecuted following incidents of sexual assault.

### 5.8 Suspected and actual suicide

There were 40 suspected and actual suicides of patients reported during 2011/12. The tables below show a breakdown of the figures by CAG. Table four shows a comparison data with previous year reports of suspected and actual suicide.

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<td>Lambeth</td>
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<td>Lambeth</td>
<td>Recently discharged</td>
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<td>39</td>
<td>North A&amp;T</td>
<td>MAPD</td>
<td>Lambeth</td>
<td></td>
</tr>
<tr>
<td>40</td>
<td>Croydon HTT</td>
<td>Psych Med</td>
<td>Croydon</td>
<td></td>
</tr>
</tbody>
</table>
A table showing the number of community patients, inpatients on ward, inpatient on leave/absent, and total for various years:

<table>
<thead>
<tr>
<th>Year</th>
<th>Community patient</th>
<th>Inpatient on ward</th>
<th>Inpatient on leave/absent</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>2011/12</td>
<td>36</td>
<td>1</td>
<td>3</td>
<td>40</td>
</tr>
<tr>
<td>2010/11</td>
<td>26</td>
<td>0</td>
<td>2</td>
<td>28</td>
</tr>
<tr>
<td>2009/10</td>
<td>34</td>
<td>1</td>
<td>3</td>
<td>38</td>
</tr>
<tr>
<td>2008/9</td>
<td>17</td>
<td>0</td>
<td>3</td>
<td>20</td>
</tr>
<tr>
<td>2007/8</td>
<td>39</td>
<td>0</td>
<td>3</td>
<td>42</td>
</tr>
</tbody>
</table>

Table five: Comparison of suspected and actual suicide reports with previous years

Examples of actions taken and improvements made to minimise the risk of recurrence of suicide:

- All incidents of suspected or actual suicide are investigated by a suitably qualified and experienced team. A Trust Investigation Facilitator is frequently involved in these investigations and where necessary a Board Level Inquiry is commissioned.
- The Patient Safety Team are working towards ensuring that a Board Level Inquiry is undertaken as soon as possible after the completion of the Structured Investigation. This helps to ensure prompt reporting and learning.
- Synopsis reports on suspected or actual suicide were created and shared with the CAGs and Primary Care Trusts to help inform service design and awareness of trends.
- It was noted that a majority of suicides were reported by MAPD CAG frequently involving recently referred and assessed patients. The CAG worked to ensure prompt reporting and investigations of such incidents and have made plans to extract key relevant aspects of the DH Suicide Prevention Strategy to assist in informing and improving day-to-day practice.
- Coroners now routinely hold their inquest only after receiving the Trust structured investigation report. The Patient Safety Team is of the view that this measure has also contributed to the improvement in the quality and timeliness of investigation reports.
- During 2011/12, the Patient Safety Team with the assistance of the Clinical Audit and Effectiveness Team continued to implement and monitor the NPSA Preventing Suicide Toolkit which is aimed at reducing the likelihood of patient suicide during admission or in the period of high risk following discharge from hospital.
- The Patient Safety Team contributed to the preparation and dissemination of the Trust Ligature Point Control and Audit Pack which was circulated in January 2012 and has led to high risk areas being identified and dealt with.

5.9 Deaths (including patient suicides)

There were 480 patient deaths reported during 2010/11 compared to 450 reported during 2009/10 and 429 reported during 2008/9. As with previous years there was a peak during the winter months (an overall average of 40 reported deaths per month increasing to 50 reported deaths month during December 2010 and January 2011).
The majority of deaths were reported by the MHOA&D CAG and the majority of these happened in facilities separate from the Trust. There was an increase in the number of deaths reported by the CAG from 180 reported during 2009/10 (a decrease of 55 from the previous year) to 273 reported during 2010/11.

There was a reduction in the deaths of patients under the care of the Addictions CAG: 43 reported in 2009/10 to 36 reported in 2010/11.

Trust staff are advised to report all patient deaths including those of recently discharged patients and those where the patient is under the care of another health organisation for example an acute Trust. A proportionate investigation is undertaken in response to patient deaths.

Examples of actions taken and improvements made to minimise the risk of recurrence of patient death:

- Historically there was a tendency for staff to delay investigations until the coroner’s verdict was received. This no longer happens – investigations into the care and treatment of patients are commissioned as and when necessary. This is regardless of the fact that the cause of death has still to be ascertained.
- Track and trigger monitoring has now been effectively rolled out to inpatient services.
- A resuscitation audit is routinely undertaken after any incident where Cardio Pulmonary Resuscitation has been administered. The audit results help clinical teams to learn and improve their practice and assist the investigation team to have a full understanding of the incident and the staff response.
- Emergency packs are systematically inspected and training is provided around their use.
- During 2010/11, the Clinical Audit and Effectiveness Team undertook a number of audits relating to maintaining patient health. Recommendations were made to help ensure patient health. The audits included:
  - Physical intervention
  - Rapid tranquilisation
  - Do not attempt resuscitation
- A Resuscitation Bluelight Bulletin was circulated across the Trust in February 2011. The bulletin incorporated aspects of the lessons learnt from recent Trust audits and structured investigations.

5.10 Child safeguarding

Datixweb includes a field where staff can identify whether the incident they are reporting should be classified as a child-safeguarding incident. It is mandatory that all such incidents, regardless of their nature, are recorded as a serious incident. In 2010/11 there were 137 serious incidents reported confirming that the incident related to child safeguarding. This compares to 40 serious incidents reported during 2009/10 and 7 reported during 2008/9. This upward trend is the result of:

- The mandatory grading outlined above.
- The increased profile of child safeguarding across the Trust.
- Appropriate reporting thresholds across the Trust, particularly in CaMHS where for example, incidents where children go missing from foster care are reported and graded as a child-safeguarding incident.
Serious incidents involving families and children were reported in adult mental health, forensic services, CAMHS and A&E liaison services. This highlighted the need for staff to attend mandatory child safeguarding training and for all CAGs to be aware of the child safeguarding policy.

Examples of actions taken and improvements made to minimise the risk of recurrence of child safeguarding incidents
- Child safeguarding training has been rolled out to trust staff. This has enabled staff to understand when to intervene and what constitutes a child-safeguarding incident.
- Systems are in place to ensure monitoring and follow-up of child protection referrals to Local Authority Childrens Social Care Teams and clearer guidance to staff regarding the expectations relating to how they should contribute to child protection plans and conferences.
- The Trust Safeguarding Children Intranet Site has been redesigned to ensure that information is more accessible to staff in relation to national guidance and Trust policy, referral routes to the Local Authority Children Social Care Teams and sources of advice for Trust staff.
- Completion rates of child need and risk screens is available from Insight reports and this information is routinely monitored at performance management reviews.

5.11 Adult safeguarding

Datixweb includes a field where staff can identify whether the incident they are reporting should be classified as an adult safeguarding incident. It is mandatory that all such incidents, regardless of their nature, are recorded as a serious incident. In 2010/11 there were 251 serious incidents reported confirming that the incident related to adult safeguarding. This compares to 90 serious incidents reported during 2009/10 and 7 reported during 2008/9. This upward trend is the result of:
- The mandatory grading outlined above.
- The increased profile of adult safeguarding across the Trust.
- Attendance at adult safeguarding training has become mandatory.
- Appropriate reporting thresholds across the Trust, particularly in the Behavioural and Developmental Psychiatry CAG where there has been a concerted effort to acknowledge and report adult safeguarding incidents.
- The Trust Adult Safeguarding Committee includes representation from across the Trust and from Local Authorities.
- Reporting and investigation thresholds have been refined during 2010/11 to ensure that investigations are undertaken which meet the requirements of both the Trust and its stakeholders.

Examples of actions taken and improvements made to minimise the risk of recurrence of adult safeguarding incidents
- Training in adult safeguarding was made mandatory during 2009 and this has continued to be rolled out during 2010/11.
- The Trust Adult Safeguarding Policy was reviewed during 2010. The review took into account lessons learnt from the audit undertaken by the Clinical Audit and Effectiveness Team as well as lessons learnt from structured investigations.
- Safeguarding leads were established in the CAGs. Their role is to help ensure that incidents are reported and that the response is sufficient and meets the requirements of the Trust and its stakeholders.
6. Trust wide improvements arising from serious incident investigations

The majority of structured investigations make recommendations to be introduced locally. Trust wide recommendations are made relatively rarely and tend to relate to policy amendment, circulation of Trust wide bulletins and audit. The following are some examples of service improvements made in response to the lessons learnt from serious incidents during 2010/11:

- The following policies and procedures were amended in light of the findings of serious incident investigations and Board Level Inquiries:
  - Clinical records policy
  - Being open Policy
  - Observation and engagement policy
- The content of data protection training has been amended in response to an investigation into a serious incident.
- Guidance on the response to patient non-attendance was circulated to Croydon adult mental health staff.
- A flow chart identifying the actions to be taken by liaison mental health staff following patient assessment at an Accident and Emergency was introduced and later shared Trust wide.
- Systems to ensure that carers and relatives receive information following an unexpected death have been put in place in response to the findings of several structured investigations. Bereavement packs are routinely given to people affected by the suicide of a loved one.
- Bulletins were circulated in response to an increase in the use of ligatures, including shoe laces, tights and handbag straps, for the purposes of self-harm/attempted suicide in a number of inpatient wards during the third quarter.

The process for learning lessons and making improvements has become more dynamic with the introduction of CAGs. For example, a lesson learnt by a home treatment team is now routinely shared across the CAG with similar teams given that they will fall within the same CAG structure.

7. CAG structured investigations, reports and panels

During 2010/11, the Patient Safety Team worked towards amending existing systems to reflect the new CAG structures for example:

- Datix was reviewed to ensure effective CAG reporting while maintaining a historical record of previously reported directorate incidents.
- Report templates, for example the Trust Fact-finding report, were amended to ensure CAG requirements are met.
- Common terms of reference for the CAG Serious Incident Panels were introduced in October 2010. The CAG Serious Incident Panels are now firmly established.

The Patient Safety Team have also worked towards devolving the administration of serious incidents to the CAGs. The objective of this is to enable the CAGs to have greater authority and oversight of incidents and serious incidents while the Patient Safety Team retain a governance and advice function.
During 2010/11, the process of investigation and report quality assurance was reviewed to ensure that investigations and reports reach sufficiently high standards. The following actions were introduced:

- Clarity over investigation commissioning. Serious incident notifications make it clear that an investigation has been commissioned and that the 45/60 working day timescale for the completion of investigation and report is in place. This is in-line with the National Patient Safety Agency Framework.
- Standard terms of reference and report templates have been introduced which assist CAGs in undertaking thorough investigations and completing reports to a high standard.
- A checklist has been introduced to ensure that investigations, reports and recommendations meet the necessary requirements. The checklist accompanies all notifications.
- CAGs have put in place local systems to ensure that investigators are identified promptly. This helps ensure that investigations and the reports that follow are completed without unnecessary delay.
- Systems have been put in place to ensure that the timely completion of investigations and reports by the directorates are closely monitored. The monitoring largely takes place via the monthly Trust Chief Executive Performance Management Reviews.

One hundred and three serious incidents were notified internally to the Trust and externally to Trust stakeholders during 2010/11. Serious incident notifications are made for the most serious incidents, for example suspected suicide of a service user and serious violence. Notified serious incidents result in the majority of structured investigations undertaken within the Trust.

The Patient Safety Team is of the view that the quality of investigations and the reports that follow have largely improved. Investigators are now more routinely involving patients, relatives and carers in their investigations and sharing the investigation findings with them. There is clear evidence indicating that where the lessons learnt have not been shared then a complaint and/or claim is more likely to follow.

There is evidence indicating that the length of time from investigation commissioning to date of report submission has reduced dramatically from almost 400 days in April 2008 to less than 100 days in July 2011.
Chart one: Mean duration of investigations

8. Trust investigation facilitator activity

Trust Investigation Facilitators Annual Report 20011/12

Twenty two structured investigations were begun in 2011/12 involving the investigation facilitators of which 14 involved Psychosis service; 3 involved Psychmed, 2 MAP, 1 MHOA&D; BDP 3, Addictions 0 and CAMHS 3 of these involved multiple CAG services 3 and one was lifted out of the serious incident process as the concerns related to broad management issues rather than incidents or patient safety concerns.

There were six homicide investigations two involved more than one CAG, there were two registered under CAMHS services but neither had engaged with services. There were two domestic homicide reviews and at the time of this report decisions had been made that four of the homicides did not meet the threshold for HSG 94/27 and two are yet to be decided, one of which has not yet been convicted and in the other case the decision had been deferred awaiting the conclusion of the DHR.

There were no Child or Vulnerable Adult Serious Case Reviews

Ten of the cases were reviewed at Board Level Inquiry.

Investigations mentored
Seventeen Level 1 investigations were mentored by the investigation facilitators, down in number from the previous year (twenty). When collecting the data for this section the investigation Facilitators found that their data collection records could be improved and the plan to establish agreements on the level of support being offered had not been successfully implemented.
## Lessons Learned in 2011/2012

<table>
<thead>
<tr>
<th>No</th>
<th>Lessons Learned</th>
<th>Examples</th>
<th>Freq’y</th>
</tr>
</thead>
</table>
| 1. | **Lack of communication/ Poor documentation** | From wards and CMHTs to families  
Between wards and CMHT’s  
Within ward teams  
  - information from ward round not being cascaded to the rest of the team  
  - Rotas for senior medical cover of leave not shared with the entire team  
  - Lack of structure approach to MDT meetings and ward round documentation did not incorporate key information  
Inaccessible paper records in psychology/psychotherapy services  
Poor information sharing in adult safeguarding incidents  
Low expectations of GP referrals but no action taken to liaise with primary care to address this.  
Lack of clarity about leave status  
Cut/paste entries on ePJS Events  
Lack of clarity in recording of medication regarding TTAs | X6  
X5  
X5  
X2  
X2  
X2  
X2 |
| 2. | **Risk management and Care planning** | Risk management and Care planning in psychology/psychotherapy services x1  
No systematic assessment risks or formulation of care plans or management plans and mechanisms for staff to explore risk beyond immediate plans were not utilised.  
Risk assessments not updated following significant risk events  
Absence of up to date care plans and risk assessments. The latter were of particular relevance in the context of risk history which is, it is accepted, a predictor of future risk events. | x3     |
| 3. | **Poor compliance with Trust policies** | in relation to:  
1. Observation and Engagement  
   i. observations at night –  
   ii. checks for breathing /  
   iii. deaths during night)  
2. Physical Health Care  
   i. MEWS charts not reviewed at ward round (2),  
   ii. MEWS charts not completed (3),  
   iii. DVT for patients spending elongated periods in bed (2)  
3. Incident Policy  
4. CPA  
   i. An absence of understanding of the importance of clinical documentation as defined by the Trust CPA | x 3  
x 7  
x2  
x2 |
The investigators believe that the lack of CPA and medical reviews represented a lost opportunity to explore mental health needs, in the context of his overwhelming and intractable social problems.

4. **Bleep/Alarm Systems**
   - Reported problems of duty doctors not receiving calls to their bleeps on both Bethlem and Maudsley sites
   - Limitations in Ascom radio system

5. **Referral procedures**
   - Process between YOS and CAMHS requires review.
   - Referral and waiting list procedures in psychology/psychotherapy services require review

7. **Other significant issues**
   - Divisions between staff groups that made standards difficult to maintain.
   - Concerns about the effective functioning of assurance systems on a ward;
   - Limited cooperation/shared working with the police
   - There is little guidance for care coordinators or teams for managing a situation where a family are destitute and children are involved.

In comparison with previous years the themes of poor compliance with trust policies communication and documentation and clinical Risk Assessment and the Management of Harm remain key themes. New themes were around alarm/bleep systems and referral procedures and single significant themes include a lack of guidance on managing destitute families; there was a significant reduction in delays in investigations commencing.

**External Investigations**
In 2011/12 the investigation facilitators were called as witnesses in two independent external investigations commissioned by NHS London. The independent investigations were both completed within 2011/12

Investigation facilitators have also been called to give evidence at inquests for the first time this year. It is anticipated that the authors of SI reports will be called to give evidence at inquests more frequently in the future.

An external investigation by the HSE has been in progress for the past eighteen months and the investigation facilitators have been coordinating information requests, interviews of staff, managers etc during this time. It is anticipated that this may conclude some time in 2013.

**Other Work completed**
Policy reviews in line with the NHSLA framework
- Incidents Policy – major revision
- Staff Support – minor revision
- Investigations Policy – major revision in line with NHSLA and NPSA national framework guidance.
In parallel to the policy revisions the investigation facilitators made audit proposals and went on to complete fieldwork and audit reports on compliance with the Incidents, Staff Support and Investigations policies.

There was a major revision of SI report templates with the introduction of Level 1 (concise) and Level 2 comprehensive reports. In February 2012 there was a further revision of the executive summary and action plans to draw them in line with the requirements of local PCT’s.

Since the original reviews in December 2011 the Investigations Policy has had a further review to bring it into line with NHSLA requirements published in 2012.

The investigation facilitators have also worked on developing their relationships with commissioning PCTs and NHS London. They attend regular meetings with the NHS London Patient Safety Lead, providing regular reports on case progression of the most serious cases such as homicides.

**Practical Guide to Structured Investigations**

Revision of the Practical Guide to Structured Investigations book was largely completed in 2011/12 however there have been some delays in completing the 8th edition which it is hoped will be printed in the new year.

Training in complaint and serious incident investigations is mandatory for managers conducting investigations and provided by the Practical Guide to Structured Investigations programme. The one day course aims to provide an understanding of structured investigation methodology, to provide practical experience of useful tools, techniques that make up the systematic pathway to effective investigations and targeted solutions.

Places for 160 attendees were available over 2011/12 with 129 people actually attending - 81% compared with 73% attendance in 2010/11.

From 1 April 2011 until 31 March 2012, CAG representation on the training was

<table>
<thead>
<tr>
<th>Description</th>
<th>Number Attended</th>
</tr>
</thead>
<tbody>
<tr>
<td>Addictions</td>
<td>1</td>
</tr>
<tr>
<td>MHOA&amp;D</td>
<td>9</td>
</tr>
<tr>
<td>B&amp;DP*</td>
<td>32</td>
</tr>
<tr>
<td>Psychological Medicine</td>
<td>5</td>
</tr>
<tr>
<td>CAMHS</td>
<td>6</td>
</tr>
<tr>
<td>MAP</td>
<td>7</td>
</tr>
<tr>
<td>Clinical Neurosciences</td>
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<td>Psychosis</td>
<td>49</td>
</tr>
<tr>
<td>Estates &amp; Facilities</td>
<td>2</td>
</tr>
<tr>
<td>Nursing &amp; Education 1</td>
<td>1</td>
</tr>
<tr>
<td>Unknown</td>
<td>16</td>
</tr>
</tbody>
</table>

*A dedicated session was held in January 2012 for the B&D CAG which was attended by 15 staff.

**Professional group profile**

Of the 129 staff that attended training the profile by professional group was:

<table>
<thead>
<tr>
<th>Description</th>
<th>Number Attended</th>
</tr>
</thead>
<tbody>
<tr>
<td>Psychotherapist</td>
<td>1</td>
</tr>
<tr>
<td>Occupational Therapist</td>
<td>9</td>
</tr>
<tr>
<td>Administration Staff (Other)</td>
<td>6</td>
</tr>
<tr>
<td>Consultant Psychiatrist</td>
<td>13</td>
</tr>
<tr>
<td>Nurse Advisor</td>
<td>1</td>
</tr>
</tbody>
</table>

68 of 103
Clinical Psychologist 9
Ward/CMHT/Crisis Nurse 24
Clinical Services Lead 1
Section/Team/Ward Manager (Leader) 30
Pharmacist 1
Business/Development Manager
H&S Coordinators
Corporate Manager 2
Corporate Other
Service / Medical / Other Director
Senior Social Worker
CAMHS Safeguarding Lead 1
Governance Lead
Art Therapist 1
External
Not Specified 30
Total 129

Report and Response Writing Training
This course continues to be offered to teams/service at a local level and has had a limited uptake this year with only one for Psychosis and MAP Team Leaders in Lambeth requesting the training.

Intranet Sites
The SI Website continues to be reviewed and updated in response to the changes in national and local requirements.

The Staff Support Website has been developed with links to a number of internal and external support agencies.

Other Projects
The investigation facilitators were involved in the development of a joint learning project with SLaM, the Metropolitan Police and London Ambulance Service where a DVD featuring staff from all three services is being developed as a shared learning tool for managing emergency situations involving mental health patients.

Plans for 2012/13
- To improve completion times for Level 1 and 2 investigations to ameliorate the impact of the proposed PCT fines.
- To improve quality of SI investigations and reports to reduce the likelihood of Rule 43 judgments from Inquests

9. Trust Serious Incident Committee
The Trust Serious Incidents Committee is chaired by the Chair of the Trust. During 2010/11, the Trust Serious Incident Monitoring Committee met three times and reviewed and monitored:
- The review and monitoring of Trust Incident and Investigation policy and procedures;
- Levels of incident reporting across the trust;
- Improvements to the serious incident management and investigation process;
• Effectiveness of systems in place for the implementation of recommendations arising from structured investigations;
• Processes and procedures in place to comply with national policy for example Child and Adult Safeguarding procedures;
• The outcome and findings of the Board Level Inquiries that were undertaken;
• The status of independent investigations carried out under HSG 94(27);
• Terms of reference and membership and activity of the CAG Serious Incident Panels.

10. Independent investigations commissioned under HSG 94(27)

All homicides committed by individuals in the care of mental health services in England are investigated by the mental health trust that provided their care. Strategic Health Authorities (SHAs) also have a responsibility to investigate these incidents. In their guidance on The Discharge of Mentally Disordered People and their Continuing Care in the Community (HSG (94)27) – and the amendment published in 2005 – the Department of Health set out what organisations should do following a mental health homicide. It says that mental health trusts and SHAs should:
• Carry out an initial management review (usually within 72 hours) to identify any immediate concerns (mental health trust).
• Commission an internal investigation to establish a chronology of events and determine possible shortcomings in the care provided (mental health trust).
• Commission an independent investigation (SHA).

The Patient Safety Team have worked to establish links with counterparts in NHS London to ensure that proportionate independent investigations are commissioned and commenced in a timely manner. One independent investigation commenced in 2011 (homicide following the absconding of a Schedule one offender). It is expected that this, and a further two investigations, will be undertaken and completed during 2011.

11. Coroner Rule 43

During 2010/11, the Trust received and responded to four Coroner Rule 43 notices. These notices were submitted to the Trust in response to inquests of trust patients. They largely related to ensuring improved communication between services but also touched upon improving housing provision for particular patient groups. Systems were put in place within the Trust to ensure the timely acknowledgement and response to such letters.

12. Learning Lessons reports and blue light bulletins

Four quarterly Learning Lessons reports were produced and circulated during 2010/11 to directorate/CAG management teams, commissioning Primary Care Trusts (PCTs) and to NHS London who continue to use the report as a suggested template for other London mental health trusts. Patient safety bulletins were also circulated with the expectation that these were sent onto clinical staff.

During 2010/11, three internal blue light bulletins were circulated in response to urgent safety concerns:
• Safe use of Clozapine (September 2010)
• Calling for police assistance (October 2010)
• Resuscitation (February 2011)

13. **Presentations and training**

The following presentations were given during the course of 2010/11:
- CaMHS Clinical Governance session
- Addictions CAG Clinical Governance session
- Team Leader/ward Managers Day: February 2011
- Management of violence and aggression study day: February 2011

A number of ad hoc reports have been completed to assist staff in understanding local incident trends:
- Synopsis report: Deaths of patients: Psychosis CAG
- Violence and aggression on single-sex wards

14. **Investigations and inquiries into outside organisations**

The Patient Safety Team review and monitor independent investigation reports relating to outside organisations. Where lessons can be learnt these reports are then systematically raised at the Clinical Risk Committee (CRC) and at the Directorate Clinical Governance Committees. The reports reviewed and raised during 2010/11 included:
- A summary of the independent investigation into the care and treatment of patient Tennyson Obhi was reviewed at the Trust Clinical Risk Committee in January 2011.
- The Annual Report of the National Confidential Inquiry into Suicide and Homicide by People with Mental Illness was subjected to review at the Trust Clinical Risk Committee in September 2010.
- The Care Quality Commission (CQC) Investigation follow-up report into West London Mental Health Trust. The findings of the investigation were raised and discussed at the Trust Clinical Risk committee and at relevant directorate/CAG governance meetings.

15. **Reports from external agencies**

- National Reporting and Learning Service report: September 2010

In September 2011 the National Reporting and Learning Service Report showed the Trust is doing well in terms of overall incident reporting (particularly low harm and near miss incidents). The report showed that the Trust is one of the highest reporting mental health trusts in the country (11th out of 58).

*Organisations that report more incidents usually have a better and more effective safety culture. You can’t learn if you don’t know what the problems are.*

*NPSA: September 2011*
• Care Quality Commission: Staff Survey 2010

Results of the 2010 National NHS Staff Survey

Key finding 22: Fairness and effectiveness of incident reporting procedures

(\textit{the higher the score the better})

<table>
<thead>
<tr>
<th></th>
<th>Scale summary score</th>
</tr>
</thead>
<tbody>
<tr>
<td>Trust score 2010</td>
<td>3.50</td>
</tr>
<tr>
<td>Trust score 2009</td>
<td>3.41</td>
</tr>
<tr>
<td>National 2010 average</td>
<td>3.45</td>
</tr>
<tr>
<td>Best 2010 score</td>
<td>3.75</td>
</tr>
</tbody>
</table>

Staff were asked questions to assess the culture of error and incident reporting in their trust. In particular, the questions asked whether staff are aware of the procedures for reporting errors, near misses and incidents; to what extent staff feel that the trust encourages such reports, and then treats the reports fairly and confidentially; and to what extent the trust takes action to ensure that such incidents do not happen again.

Possible scores range from 1 to 5, with 1 representing procedures that are perceived to be unfair and ineffective, and 5 representing procedures that are perceived to be fair and effective.

• The SLaM score of 3.50 was above (better than) average when compared with trusts of a similar type.
• It is also a statistically significant increase since 2009 i.e. a better score than in 2009 when the trust scored 3.41.
<table>
<thead>
<tr>
<th><strong>TRUST BOARD OF DIRECTORS – SUMMARY REPORT</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Date of Board meeting:</strong></td>
</tr>
<tr>
<td><strong>Name of Report:</strong></td>
</tr>
<tr>
<td><strong>Heading:</strong></td>
</tr>
<tr>
<td><strong>Author:</strong></td>
</tr>
<tr>
<td><strong>Approved by:</strong></td>
</tr>
<tr>
<td><strong>Presented by:</strong></td>
</tr>
</tbody>
</table>

**Purpose of the report:**

To present the Board’s Assurance Framework Report, which comprises a summary of the principal risks that threaten the achievement of the Trust’s objectives.

**Action required:**

The Board of Directors is asked to:

1) Review the Assurance Framework Report to confirm that it represents the principal risks that threaten the achievement of the Trust’s objectives and that these risks are appropriately and consistently scored.

2) Review the active risks within the Assurance Framework Report to confirm that the actions to mitigate and manage these risks are correctly identified and progress with these actions is satisfactory.

3) Review the new inherent risks within the Assurance Framework Report to confirm the robustness of assurances and that these are currently under control.

**Recommendations to the Board of Directors:**

Accept the attached Assurance Framework Report, subject to any changes agreed by the Board.

**Relationship with the Assurance Framework (Risks, Controls and Assurance):**

This paper forms the basis of the on-going process that ensures; risk identification, mitigation and management comply with the requirements of the Assurance Framework.

**Summary of Financial and Legal Implications:**

The Assurance Framework underpins the statutory requirement to produce an Annual Governance Statement, which confirms that the Trust is appropriately and effectively governed and managed.

**Equality & Diversity and Public & Patient Involvement Implications:**

The Assurance Framework enables the Board to assess and manage the organisation’s principal risks and ensure that the Trust’s strategic aims are achieved.
1. Background

The Assurance Framework (AF) is a Board owned document aimed at assisting the Trust to identify, manage and mitigate major risks to achieving its most important service and business objectives, to be assured that the risk appetite of the Trust is considered and appropriate and that adequate controls are operating to ensure risks are contained within this appetite level.

Guidance from the Department of Health states that Boards must be appropriately engaged in developing and maintaining their Assurance Frameworks; scrutiny is important to the Assurance Framework process and the Trust’s principal strategic risks need to be reviewed and challenged systematically. It is also the whole Board’s duty to ensure that assurances are adequate and that action plans to address gaps in assurance or control are appropriately prioritised, monitored and progressed.

The Trust’s Risk Management and Assurance Strategy (October 2012) merges the ‘top down’ strategic view of the principal risks that threaten the Trust and the ‘bottom up’ operational view of the principal risks that threaten the achievement of local objectives into a single repository of Trust-wide risks. These risks are designated as ‘active’, if actions are still underway to lower their risk score, or ‘inherent’, if they are currently under control. The Board of Directors has delegated the detailed scrutiny of the AF to the Trust’s high level committees with responsibility for risk (the Audit Committee, Service Quality Improvement Committee and Trust Executive); subsets of the combined Assurance Framework / Organisation-wide Risk Register are reviewed in detail by these committees as appropriate.

The full and detailed Assurance Framework can be found on the Trust intranet. The following sections identify the principal active strategic and operational risks that could threaten the achievement of the Trust’s objectives, briefly analysing the implications for the Trust, current status of the risk, and progress with managing and mitigating the risk. The final section summarises the principal inherent risks that are currently considered under control.

The Risk Analysis Tool at Attachment 1 defines the Trust’s understanding of the risk ratings used within the Assurance Framework.

2. Risk Area: Innovative culture and quality focus

2.1 TW44: Failure to manage capacity of acute beds, leading to unacceptable clinical care and/or increased financial pressures (additional nursing costs / private beds).

Current score: 20, previous reported score: 20

Croydon Triage has opened with eleven male beds and a substantive consultant has been appointed to Gresham 1. Apart from the operational and qualitative concerns overspill generates, it is critical that any additional capacity provided and any additional activity delivered is fully funded by Clinical Commissioning Groups in future years.

2.2 TW02: High levels of incidents of aggressive/violent behaviour can give rise to injury to staff members and service users; this may lead to patient injury or an unsatisfactory in-patient experience, poor staff morale, fear, sickness absence and backfill costs, or litigation and criminal damage to Trust property and premises.

Current score: 20, previous reported score: 20

Immediate risks addressed, with action plans produced to address longer-term issues. Good progress is being made against the action plans, but specific wards are still faced with considerable risks.
2.3 TW48: Responsible Clinicians may fail to record the assessment of capacity for detained patients both at the start of section and at the three month stage (Section 58). This is monitored by the CQC both at Compliance visits and MHA Monitoring visits and failure to comply could affect Registration.
Current score: 15, previous reported score: 20
This is no longer mentioned as frequently in CQC inspections and a Section 58 audit undertaken in November 2011 found High Compliance (83%) with the recording of capacity to consent; risk score reduced.

2.4 TW45: Risk of injury to staff, visitors and patients on Trust premises where insufficient or unsuitable panic alarms systems are installed, leading to litigation and adverse media coverage.
Current score: 20, previous reported score: 20
Immediate risks addressed, with an action plan produced to address longer-term issues. Good progress is being made against the action plan with the risk score likely to reduce in the next six months, once the agreed contract is implemented.

2.5 TW52: The inadequate design and fabric of supervised confinement suites has lead to incidents of them being destroyed and patients able to arm themselves, potentially causing injury to self or others. Several incidents have required police involvement, consideration to evacuate a PICU and the need to close a suite for repair, resulting in it not being available for patients that clinically required it.
Current score: 20, previous reported score: 20
Immediate risks addressed, with an action plan produced to address longer-term issues. Supervised Confinement Policy agreed, but serious incidents are still occurring.

2.6 TW53: Risk of injury to patient or staff whilst in transit.
Current score: 20, previous reported score: 20
Immediate risks addressed, with action plan produced to address longer-term issues. Good progress is being made against the action plan, with risk score likely to reduce once the Transporting Patients Policy and Risk Assessment Tool (currently under consultation) are implemented.

2.7 TW16: Failure to identify and act on Vulnerable Adult Safeguarding concerns; failure to comply with policy in relation to acting on Safeguarding Vulnerable Adult concerns and failure to meet CQC standards in relation reporting and registration.
Current score: 16, previous reported score: 16
A new structure is out for consultation and a full time lead will be appointed within the next three months.

3. Risk Area: Finance

3.1 TW54: Failure to deliver the financial plan for 2012/13.
Current score: 8, previous reported score: 16
This risk is now moderate and the Trust’s overall financial position is acceptable, but is reliant upon achieving CQUIN targets above plan and ensuring that the Trust can recover risk reserve funding from PCTs to cover gaps in PCT QIPP. The Trust is forecasting that it will deliver to plan and possibly generate a small additional surplus, but this is only being achieved by deploying reserves (as planned) and making use of additional fortuitous income generated in-year. The underlying pressure on operational budgets is currently £6m, mainly associated with additional activity, late or incomplete delivery of planned savings and over optimistic income assumptions for some “traded” activities; there also remains a requirement to address significant overspending in some CAGs and Estates. These underlying budget pressures are being addressed as part of the 2013/14 Plan.
3.2 ST32: Failure to contain additional cost pressures in 2012/13.
Current score: 16, previous reported score: 16
Risk remains high, with an action plan produced to mitigate it; the position is mixed: although controls over drug usage have impacted and slowed the rate of overspend, other main cost drivers continue. Acute overspill remains high despite the opening of the Bethlem Triage, forensic placements have not reduced in Lambeth as expected and ward nursing costs continue to be above budget across a number of areas.

3.3 ST33: Failure to agree the 3 year financial plan for 2012/15.
Current score 20, previous reported score: 16
As negotiations start for 2013/14, the risk of not achieving contractual agreement and a balanced budget are high. This is mainly because the commissioning intentions and funding envelopes of commissioners are yet to be fully clarified and the Trust's ability to deliver significant savings and service transformation is only beginning to be tested. In addition, the allocations to local Clinical Commissioning Groups in the first instance appear to be lower than expected and the emergence of CCGs and increased central specialist commissioning raises further risks and uncertainties. A detailed project plan and timetable exists to manage this risk.

3.4 ST03: Lack of timely and accurate performance information and metrics to support contract delivery, resulting in fines, failure to deliver against targets and under recovery of income.
Current score: 16, previous reported score: 16
See notes at 3.5 (TW55) and 4.2 (ST21).

3.5 TW55: Failure to achieve targets because of inadequate performance.
Current score: 16, previous reported score: 16
The Trust is currently set to exceed, in overall terms, its CQUIN quality targets and thus secure more than the planned level of income associated with these targets. However, there remain a couple of areas where the Trust may be subject to sanctions for non-delivery of targets, and action plans are in place to deal with these areas.

3.6 ST15: Significant changes to the commissioning environment are changing individual relationships, systems and processes. Income reducing commissioners are looking for discounts.
Current score: n/a, previous reported score: 16
This risk, as stated, no longer exists but attention is drawn to the note at 3.3 (ST33).

4. Risk Area: Operational focus

4.1 ST30: Failure to evidence Monitor's Compliance Framework.
Current score: 16, previous reported score: 20
The actions taken have resulted in achieving a Green governance rating from Monitor in Q2, and therefore a reduced risk score. The action plan continues to be implemented and further risk reduction is planned over the next reporting period.

4.2 ST21: Inadequate data to support the Quality Strategy, leading to failure to monitor and evidence progress.
Current score: 16, previous reported score: 16
An action plan to address data quality, completeness and classification issues is being produced; implementation is due to be completed by April 2013.

4.3 ST06: Failure to achieve 100% uptake of appraisals and PDPs, leading to failure to comply with CQC Registration standards.
Current score to be determined.
There has been a marginal increase in the uptake of appraisals from 2011 to 78% in 2012 and the staff survey reports a demonstrable improvement in the quality of appraisals.

5. Action
The Board of Directors is asked to note the current status of the principal active risks facing the Trust and the overall progress being made against the actions planned to manage and mitigate them.

6. Inherent Risks
Sixteen inherent risks were reported to the June meeting of the Board of Directors, thirteen of which come from the National list of Never Events that are applicable to Mental Health trusts and the remaining three having been previously removed from the Trust’s Assurance Framework. A further three risks have now been designated as ‘inherent’, this decision being ratified at the Service Quality Improvement Sub Committee:

6.1 Failure to learn from and embed recommendations arising from BLIs, SIs & Complaints, leading to repetition of avoidable incidents & complaints.
   A clinical audit undertaken in November 2011 found good systems for learning lessons; a follow-up audit in March 2012 concluded that actions arising from the previous audit have reduced this risk to an acceptable level.

6.2 Non-compliance with Section 58, Consent to Treatment, MHA 1983, leading to unlawful medication and possible litigation.
   Electronic forms are now used to send requests from Responsible Clinicians to SOAD service, which has greatly reduced the likelihood of this risk.

6.3 Death or serious harm to a mental health inpatient as a result of suicide using non-collapsible curtain or shower rails. (Never Event)
   A curtain rail audit was undertaken in April 2012, and all non-collapsible curtain rails have now been replaced. A ligature audit has also been undertaken at the Kings College Hospital A&E Dept.

Two inherent risks have also been identified by the Strategy and Business Development Directorate and added to the Assurance Framework:

6.4 Equalities, human rights and disability legislation.
   Assurances include reports to Trust Executive and Board, clinical governance audits, (lack of) complaints, staff and patient surveys and disability benchmarking.

6.5 Failure to adhere to PPI legislation.
   Assurances include reporting mechanisms into the Trust Executive, patient surveys and monthly performance review of local PEDIC.

By definition, no gaps in control or assurance are currently identified for these risks and so no actions are planned to mitigate the risk further.

7. Action
The Board of Directors is asked to review the new inherent risks within the Assurance Framework Report to confirm the robustness of the assurances and that these risks are currently under control.

8. Next Steps
The strategic risks that could threaten the achievement of the Trust’s objectives will be reviewed as part of the annual planning process and included in the 2013/14 Annual Plan; these will be brought to the April meeting of the Board of Directors.
# PART 1: RISK IMPACT GRADING

<table>
<thead>
<tr>
<th>GRADES</th>
<th>CATEGORY</th>
<th>INJURY</th>
<th>STATUTORY COMPLIANCE</th>
<th>SERVICE CONTINUITY</th>
<th>FINANCE</th>
<th>REPUTATION</th>
</tr>
</thead>
<tbody>
<tr>
<td>Grade</td>
<td>Category</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>5</td>
<td>CATASTROPHIC</td>
<td>Fatality/Fatalities. (including non-preventable deaths, homicide, suicide, death by accidental causes and sudden and unexpected deaths)</td>
<td>Sustained failure to meet national professional standards and/or statutory requirements e.g. failure to meet the requirements of: Mental Health Act, HASAWA 74, DDA, Data Protection Act, Medical Records Act etc.</td>
<td>Service closed for in-determinant period</td>
<td>&gt; £10M</td>
<td>National media &gt; 3 day coverage</td>
</tr>
<tr>
<td>4</td>
<td>SEVERE</td>
<td>Injury requiring immediate hospital admission for more than 24 hours (RIDDOR reportable)</td>
<td>Intermittent Failure to meet professional standards and/or statutory requirements e.g. failure to meet the requirements of: Mental Health Act, HASAWA 74, DDA, Data Protection Act, Medical Records Act etc.</td>
<td>Service suspended for &gt;24hours</td>
<td>£1M - £10M</td>
<td>National media &lt; 3 day coverage, Department executive action</td>
</tr>
<tr>
<td>3</td>
<td>SIGNIFICANT</td>
<td>Injury causing member of staff to take &gt; 3 days absence from work (RIDDOR Reportable)</td>
<td>Failure to meet internal professional standards and/or national performance standards e.g. failure to meet the requirements of: Mental Health Act, HASAWA 74, DDA, Data Protection Act, Medical Records Act Trust policies and procedures etc.</td>
<td>Service suspended for &lt;24 hours</td>
<td>£100K - £1M</td>
<td>Regulator Concern, Local press coverage on &gt;1 issue</td>
</tr>
<tr>
<td>2</td>
<td>MODERATE</td>
<td>Abrasions/bruises</td>
<td>Failure to meet internal standards e.g. failure to comply with Trust policies/guidelines</td>
<td>Some service disruption for &lt; 24 hours</td>
<td>£5K - £100K</td>
<td>Within unit, Local press coverage on 1 issue</td>
</tr>
<tr>
<td>1</td>
<td>LOW</td>
<td>No injury</td>
<td>Minor non-compliance</td>
<td>None</td>
<td>&lt; £5K</td>
<td>None</td>
</tr>
</tbody>
</table>
PART 2: RISK RATING

<table>
<thead>
<tr>
<th>Impact</th>
<th>1 Remote</th>
<th>2 Unlikely</th>
<th>3 Possible</th>
<th>4 Likely</th>
<th>5 Certain</th>
</tr>
</thead>
<tbody>
<tr>
<td>1 Low</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>2 Moderate</td>
<td>2</td>
<td>4</td>
<td>6</td>
<td>8</td>
<td>10</td>
</tr>
<tr>
<td>3 Significant</td>
<td>3</td>
<td>6</td>
<td>9</td>
<td>12</td>
<td>15</td>
</tr>
<tr>
<td>4 Severe</td>
<td>4</td>
<td>8</td>
<td>12</td>
<td>16</td>
<td>20</td>
</tr>
<tr>
<td>5 Catastrophic</td>
<td>5</td>
<td>10</td>
<td>15</td>
<td>20</td>
<td>25</td>
</tr>
</tbody>
</table>

To rate a risk:
1. Grade the impact of the worse case scenario [Part 1].
2. Multiply this impact [1-5] by the likelihood [1-5], to get the rating.

PART 3: RISK MANAGEMENT - ACTION AND TIMESCALES

<table>
<thead>
<tr>
<th>KEY</th>
<th>Risk Level</th>
<th>Action and Time scales</th>
</tr>
</thead>
<tbody>
<tr>
<td>RED</td>
<td>CATASTROPHIC 20 – 25</td>
<td>Immediate action must be taken to manage the risk. Control measures should be put into place which will have the effect of reducing the impact of an event or the likelihood of an event occurring. A number of control measures may be required.</td>
</tr>
<tr>
<td></td>
<td>SEVERE 16</td>
<td>Significant resources may have to be allocated to reduce the risk. Where the risk involves work in progress urgent action should be taken.</td>
</tr>
<tr>
<td>AMBER</td>
<td>SIGNIFICANT 12 – 15</td>
<td>Efforts should be made to reduce the risk, but the costs of prevention should be carefully measured and weighed against the impact of an event. Establish more precisely the likelihood of harm as a basis for determining the need for improved control measures.</td>
</tr>
<tr>
<td></td>
<td>MODERATE 8 – 10</td>
<td>Efforts should be made to reduce the risk and the likelihood of harm to be established before implementing further controls. Existing controls should be monitored and adjusted. Consideration may be given to a more cost-effective solution or improvement that imposes no additional cost burden.</td>
</tr>
<tr>
<td>GREEN</td>
<td>LOW 1 – 6</td>
<td>Acceptable risk. No further action or additional controls are required. Risks at this level should be monitored, and reassessed at appropriate intervals.</td>
</tr>
</tbody>
</table>
Date of Board meeting: Tuesday 22\textsuperscript{nd} January 2013

Audit Committee (‘AC’):
(a) draft minutes of meeting held 11\textsuperscript{th} Dec 2012
(b) signed and sealed reports (Jul to Sep 2012 and Oct to Dec 2012)

Name of Report:

Heading: Governance

Author: Steven Thomas (AC Secretary)

Approved by:
(name of Exec Member) Robert Coomber (AC Chair and Non Executive Director – ‘NED’)

Presented by: Robert Coomber (AC Chair and NED)

Purpose of the reports:

\begin{align*}
\text{AC draft minutes.} & \quad \text{To inform the Board about proceedings at the AC meeting held on 11\textsuperscript{th} December 2012.} \\
\text{Signed and sealed reports.} & \quad \text{To inform the Board about documents signed and sealed on behalf of the Trust in the period July 2012 to December 2012.}
\end{align*}

Action required:

Review the documentation presented.

Recommendations to the Board:

Note the documentation presented.

Relationship with the Assurance Framework (Risks, Controls and Assurance):

The AC’s role includes consideration of the Assurance Framework.

Summary of Financial and Legal Implications:

No specific significant implications identified.

Equality & Diversity and Public & Patient Involvement Implications:

No specific significant implications identified.

KEY ISSUES SUMMARY (references are to the AC minutes attached)

(The AC Chair may wish to amend or expand on the following)

At its 11.Dec.2012 meeting, the AC concluded that no matters required escalation for the attention of the Board (14.1 refers). However the AC considers that the Board should be kept aware of the AC’s concerns about the following issues.

- **Planning and risk management (1.1(b), 1.1(c) refer).** Improvements are necessary to improve the ‘realism’ of planning and risk management.
- **Estates Department-related issues (8.1.1 and 8.1.2 refer).** Timescale for resolution of issues, and generic factors contributing to this as discussed at 8.1.1 and 8.1.2. The AC has flagged these matters for the Board’s attention previously.
- **The impact of the KHP process (10.2 refers).** The impact of the KHP process, for example on strategic management capacity.
NOTES
The AC Chair decides on the appropriate order in which to take agenda items at AC meetings, and this is not necessarily the order shown below. The minutes focus on recording the information and assurances provided in the meeting, in response to questions from AC members and otherwise, rather than on the questions themselves.

1. PRIVATE SESSION
1.1 A private session was held. Given that this is the first AC meeting that ND has attended since his recent interim appointment to the role of Director of Finance and Corporate Governance, the main purpose of the private session was to allow ND and the AC to discuss ND’s views on issues faced by SLaM, how best to address these and how the AC can facilitate this. Attendees agreed that the session would not be minuted, and that parties would make their own notes as appropriate. Key points covered during discussions included:
(a) ND’s view that there are no ‘fatal flaws’ in SLaM’s arrangements/position, but that some key improvements are needed;
(b) improvements to SLaM’s planning systems (strategic, operational, financial) in particular to continue improving the realism of plans and continue widening the scope of strategic planning to include regions other than the four local boroughs, whilst also progressing plans for a potential merger of the KHP bodies; and
(c) re-focusing risk management systems (including auditors) on outcomes, as opposed to process.
1.2 Action/(timescale). ST will schedule the following meetings into the AC’s workplan: (a) a private session (AC with DoF) every 6 months similar to that held 11.Dec.12; (b) CAG/service leaders (Mar.13, Jun.13 re data quality, and planning and management of changes, including commissioning); (c) GH, SM and LN (Mar.13 re Estates-related issues and lessons learned); and (d) LN (Jun.13 re effect of KHP and other changes on senior management) (Jan.13).

1.3 Action/(timescale. The AC will consider requesting ad hoc work from internal audit and/or others to enable the AC to give assurance/added value to the Board about outcomes, not simply process. ST will schedule this into the AC workplan (Mar.13).

2. APOLOGIES FOR ABSENCE
2.1 RC opened the meeting. Attendees introduced themselves as appropriate. Apologies for absence had been received from SK, although subsequently he was able to attend the meeting and did so. After due discussion the AC noted this agenda item.

3. DECLARATIONS OF INTEREST
3.1 RC asked all present to declare any relevant interests. Routine declarations were made. PCJ declared an interest as an employee of King’s College London and as Trustee of Southside Certitude Support. SK declared an interest as a member of the CNS Scientific Advisory Board of Lundbeck Co and Roche Co. SK advises and consults with pharmaceutical companies periodically. After due discussion the AC noted these declarations.

4. MINUTES OF PREVIOUS AC MEETING(S)
4.1 The AC considered the final draft minutes of the AC meeting held on Thursday 20th September 2012. After due discussion the AC approved the minutes.

5. ACTION POINTS (‘APs’) FROM PREVIOUS AC MEETINGS
5.1 The AC considered the AP list. After due discussion the AC noted the AP list. Post meeting note: with the AC Chair’s agreement ST has updated the AP list to reflect information received during the AC meeting and subsequently.

6. MATTERS ARISING (IF ANY)
6.1 No other matters arising were reported. The AC noted this agenda item.

7. KEY POINTS FROM RECENT SQIC MEETING(S)
7.1.1 JG tabled and presented this report advising that, whilst the SQIC Chair had not yet approved it, it was based on SQIC minutes which she had so approved, and in particular:
(a) JG advised that SLaM was not achieving its Quality Strategy targets, and relevant supporting data is lacking. JG advised that the SQIC Chair will be reporting this to the Board with a view to agreeing corrective actions;
(b) JG advised that the SQIC reviewed the risks on the Service Quality Assurance Framework, focusing on the major three or four such risks. JG advised that SLaM was developing metrics to assess levels of assurance obtained, and PCJ noted that this was inherently more difficult than was the case for finance-related KPIs;
(c) MH noted that external audit work relevant to SLaM’s 2012/13 Quality Accounts was on hold pending Monitor’s finalisation of the scope of the required work. As soon as possible, SLaM’s members need to select a KPI for audit review; and
(d) after due discussion the AC noted the report.

7.1.2 Action/(timescale). JG will ask the SQIC Chair (HH): (a) to liaise with Cliff Bean and the Members’ Council (Noel Urwin) as soon as possible as regards the selection of a KPI for quality audit purposes; and (b) to flag to the Board key risks affecting quality of service over the next 3 to 4 years (due to the KHP process or otherwise)

8. REPORTS FROM/DISCUSSIONS WITH SLaM MANAGEMENT (OTHER THAN FINANCE)
8.1 Acting Chief Executive’s comments on Estates-related matters
8.1.1 GH gave a verbal report, and in particular:

(a) GH advised that the Board was conscious of the urgent need to resolve the Estates-related issues, and that alternative models for delivering some aspects of the service were being considered. GH outlined the steps taken by the Director of Estates Facilities and Capital Planning to resolve Estates management issues, including searching for an interim Head of Estates; and

(b) RC noted the length of time taken in resolving estates-related issues (some dated from 3 or 4 years ago), noted the impact of this on costs and service, and asked what lessons were indicated for SLaM. GH reported that initial reviews had indicated that good progress was being made and that issues would be resolved on an appropriate timescale. However GH reported that with hindsight SLaM’s priorities should have been rapidly to appoint competent management into key Estates roles, and to integrate the Estates strategy with corporate strategy. GH considered that this indicated some issues with corporate prioritisation, but could not determine whether this in turn indicated issues with the management appraisal system as he had not been involved in relevant aspects thereof.

8.1.2 The AC discussed the lessons that SLaM could learn from its handling of Estates-related issues, and:

(a) SK noted that SLaM did not have a Chief Operating Officer, unlike many Foundation Trusts;

(b) RC noted that Human Resources protocols may have slowed resolution of Estates management issues, and noted that the management appraisal process needed to be improved and focused;

(c) RC noted that the wider picture needed to be considered when looking to identify lessons learned – it appeared that the lack of progress in resolving Estates-related issues was due to a number of more generic factors taken together, which taken separately appeared reasonable. Action point 1.2(c) in these AC minutes refers; and

(d) after due discussion the AC noted the agenda item.

9. EXTERNAL AUDIT

9.1 Updated audit plan

9.1.1 MH and AF presented the planning report, and:

(a) MH and AF advised that Deloitte was now formally appointed as SLaM's external auditor, and initial familiarisation and planning procedures were in hand. In particular Deloitte had held initial meetings with GH, ND and internal audit, had reviewed the audit files of the previous external auditor, and would meet representatives of the Members’ Council and others in the New Year;

(b) AF flagged the key audit risks noted in section 2 of the report, in particular the valuation of SLaM’s £250m property assets;

(c) RC considered that the plan was appropriate and was clearly described;

(d) MH advised that Deloitte could give informal views within AC meetings on matters such as the impact of the KHP strategy on strategic management capacity, and the implications for SLaM of changes in management, but that the external audit remit did not provide an appropriate basis for formal comment on such matters. MH advised that Deloitte Consulting could be engaged to report on these; and

(e) after due discussion the AC noted the agenda item.

9.1.2 Action/(timescale). Deloitte will advise the AC of lessons learned by other clients re efficient and effective change management (with due regard to confidentiality) (Jun.13).

10. INTERNAL AUDIT (INCLUDING ICT AUDIT AND CLINICAL AUDIT IF RELEVANT)

10.1 Progress report

10.1.1 ML presented this agenda item, and in particular:

(a) ML explained that the main recommendations arising from internal audit work on SLaM’s CIP and QIPP (‘Cost Improvement Programme’ and ‘Quality Innovation, Productivity and Prevention’) related to the need to challenge key assumptions and to avoid a ‘tick box’ attitude in following the relevant processes. RC noted that internal audit work had focused on processes (which were assessed as ‘reasonable’) as opposed to outcomes (where there had been significant issues as regards achievement of plans);

(b) ND advised that SLaM had implemented some improvements with a view to improving the achievement of plans, including: additional reviews to help remove any optimism bias in setting plans; extending plans to cover two years; making key planning decisions before the Christmas holiday so that plans are ready on a timely basis by the 31 March year end; and the banning of the use of contingency reserves for purposes other than unexpected catastrophes, so that such reserves cannot be used to smooth variances caused by inappropriate planning;

(c) ML advised that SLaM’s issues were similar to those of other Trusts; and
(d) after due discussion the AC noted the agenda item.

10.2 Report on KHP-related issues (with ND)
10.2.1 DR presented this report (section 4.2 of the internal audit Progress Report refers) and:
(a) DR flagged the issues revealed by the reported Case Study, in particular as regards misunderstanding of mental health issues by physical health staff;
(b) DR advised that there was some informal contact between the internal auditors of the KHP partner bodies. RC considered it essential to improve contact (formal and informal) so that KHP Boards can obtain independent advice from auditors about KHP-related risks, to be considered with information received from parties involved in the KHP process. ND and SK noted that other bodies (including Monitor and commissioners) would have views about KHP-related issues; and
(c) after due discussion the AC noted the agenda item.

10.2.2 Action/(timescale). Parkhill will liaise, both formally and informally, with the internal auditors of other KHP partner bodies (and with ND who has general information from a recent seminar with Monitor and from commissioners) regarding the impact of and risks around the KHP process. Parkhill and ND will report to the AC and/or the Board as appropriate (Mar.13).

10.3 Report on contracts awarded without due tendering
10.3.1 ML tabled and presented this report, and
(a) ML flagged the report’s recommendations, advising that the limited testing performed had revealed no other major issues;
(b) ML advised that tender lists were complicated to use, thus increasing the risk of their being ignored;
(c) ML advised that the number of vacant substantive posts weakened review and thus control of transactions, and queried whether the Head of Estates (once the role is filled) could have sufficient time/detailed knowledge of transactions to be able to check every invoice effectively;
(d) ND suggested that use of web portals, rather than National Frameworks, for smaller projects below EU limits could yield savings of between 10% and 15%. ND advised that other Trusts were reviewing this possibility, and Ernst & Young had produced a report thereon; and
(e) after due discussion the AC noted the agenda item.

10.4 Updated internal audit plan
10.4.1 ML presented the updated internal audit plan (section 3 of the internal audit Progress Report refers). After due discussion the AC noted the agenda item.

10.5 Closure of audit agreed actions (and Computer Audit update)
10.5.1 ML advised that this would be covered at the next AC meeting, by which time follow up would have been completed. After due discussion the AC noted the agenda item.

10.6 Improving dialogue on risk management at AC meetings (with Deloitte)
10.6.1 ML and MH gave a brief verbal report on possible improvements, including:
(a) exception reporting at AC meetings. Verbal presentations of written reports at AC meetings could focus on flagging key issues for discussion, rather than outlining work done (the latter is covered in the reports themselves, circulated in the agenda papers in good time before AC meetings). The AC can request further background explanations if and as required at meetings;
(b) increased reference/linkage to the Assurance Framework as matters are discussed during AC meetings;
(c) discussions with relevant SLaM management at AC meetings about the risks they own. The action points at 1.2 in these minutes refer; and
(d) after due discussion the AC noted the agenda item.

11. LOCAL COUNTER FRAUD SPECIALIST (‘LCFS’)
11.1 Progress report
11.1.1 JL presented the LCFS Progress Report and:
(a) JL flagged the referrals shown in section 8.5 of the report. RC asked how the level of referrals could be increased, noting that most referrals came from members of staff. JL advised that the level of referrals was broadly equivalent to that at other Trusts, and that further fraud awareness training at induction
and otherwise would encourage further referrals. ND advised that such training should emphasise to staff the need to protect SLaM’s reputation and their own;

(b) JL reported that there had been no deterioration in fraud controls or in the incidence of fraud, despite the effects of changes in management and of the potential merger with other KHP bodies;

(c) JL confirmed that SLaM had not engaged the charlatan doctor noted in section 8.2 of the report; and

(d) after due discussion the AC noted the agenda item.

12. FINANCE-RELATED REPORTS

12.1 Report from Director of Finance

12.1.1 ND reported as appropriate within agenda items 12.2 to 12.7 below.

12.2 Risk Management Strategy revision

12.2.1 ND presented the revised Risk Management and Assurance Strategy (‘RMAS’), and:

(a) ND stated that none of the principal changes noted on page 92 of the agenda papers were particularly major. JG flagged a key procedural change, which is that the AC will take on the lead role in monitoring compliance with the RMAS (section 7 of the RMAS refers);

(b) RC noted that the RMAS is most comprehensive as regards processes, and that this might lead to staff applying its processes by rote. ND considered that the RMAS should be refreshed in 2013 to reduce the risk that staff might apply the RMAS unthinkingly. JG reported that most middle managers view the RMAS and its use positively, and advised that the purpose of the RMAS was to document required processes, rather than to lead change;

(c) RC noted that the type of exercise used to test the Assurance Framework (agenda item 12.6 refers, in which actual serious incidents are used to test the Assurance Framework) could also usefully be used to test the effectiveness of the processes documented in the RMAS in managing risk; and

(d) after due discussion the AC noted the RMAS, noting also that the Board approved the RMAS at its meeting on 30 October 2012 and that SLaM management will thus need to consider how to deal with the AC’s comments noted above when the RMAS is next revised, probably in 2013.

12.3 Report on risk management of 6 specified risk areas (with Parkhill and Deloitte)

12.3.1 After due discussion the AC considered that the requirement for a verbal report on 6 key areas of risk had been covered by reports given at other points in this meeting. The 6 key areas of risk noted for report were: KHP (organisational); KHP (finance-related); cost improvement programmes (‘CIPs’); Estates; service quality; and information management (AC minutes of 20.Sep.2012 meeting, section 9.5 refers).

12.4 Report on risk management

12.4.1 JG presented this report, and:

(a) RC expressed concern at the apparent low compliance rates stated (section 4.1 refers) for certain divisions. JG advised that, some departments are not expected to hold formal risk review meetings. However RC noted that the RMAS sets a unitary standard for risk management; and

(b) after due discussion the AC noted the agenda item.

12.4.2 Action/(timescale). Further to the results noted in section 4.1 of the risk monitoring report, JG will work with SLaM management to: (a) assess the adequacy of any alternative processes used by divisions with apparently poor compliance; and (b) report thereon to the SLaM executive and the AC (Mar.13).

12.5 Assurance Framework

12.5.1 JG presented the Assurance Framework (‘AF’) and the covering report flagging key changes, and:

(a) JG explained that she updates the AF based on input from senior management, but that such input has been lacking. JG advised that this means that some risks have remained relatively unchanged on the AF for a significant period. RC noted that this process seems inefficient and does not encourage ownership of risks by managers;

(b) JG advised that the AC’s role includes challenging executive management as to the AF’s content as a whole, and senior management deals with individual risks;

(c) ML commented that the AF shows sources of assurance, but does not show levels/amounts of assurance gained;

(d) the AC and ND discussed how an integrated ‘balanced scorecard/assurance report’ might support or replace the AF. One suggestion was that such a report might be produced as part of the planning
process taking account of SLaM's plans to achieve care metrics, and might include subsequent
exception reporting on issues arising/corrective action; and
(e) after due discussion the AC noted the agenda item.

12.5.2 Action/(timescale). ND plans to present an integrated risk/performance/finance report to the
Board in April 2013 (also covering relations with commissioners) and ND will ask the Board and AC
to consider if that report can support or replace the Assurance Framework reports as currently
presented to the Board and AC (Jun.13).

12.6 Test of the Assurance Framework based on major actual events
12.6.1 JG presented this report, which included a test to check whether very serious incidents (rated ‘A’ or
‘B’) were covered on the AF, and:
(a) JG reported that the SQIC reviewed whether issues occurring at the Trust/CAGs were or should be
dealt with by the AF;
(b) RC considered that the report did not indicate major problems with the AF;
(c) SK noted the large number of suicide-related incidents happening off wards; and
(d) after due discussion the AC noted the agenda item.

12.6.2 Action/(timescale). Every 6 months JG will test the Assurance Framework (as was done in
agenda item 12.6) and report to the AC thereon (Jun.13 onward)

12.6.3 Action/(timescale). JG will ask the SQIC to liaise as appropriate with other risk committees
and to commission and consider reports on the apparently large numbers of off-ward suicide-
related incidents shown by the serious incident report (agenda item 12.6), perhaps comparing with
other Trust data (Dec.12).

12.7 Signed and sealed documents, SFI breaches and STAs
12.7.1 ND presented the ‘signed and sealed’ report (covering the period July 2012 to December 2012), the
‘single quote/tender action submissions (‘STA’)’ report, and the ‘breaches of Standing Financial Instructions
(‘SFIs’)’ report. After due discussion the AC noted the agenda item and approved the proposal that the
signed and sealed report be appended to the draft minutes of the AC meeting when these are taken to the
Board of Directors for information.

13. AC-RELATED MATTERS
13.1 AC workplan for the year ahead
13.1.1 ST presented the workplan. After due discussion the AC approved the workplan, subject to update
to reflect points raised in the meeting.

13.2 AC Terms of Reference
13.2.1 After due discussion the AC noted that it was content with the AC Terms of Reference as they
currently stood, and was content for the AC Terms of Reference to be submitted to the next Board meeting
with a view to approval.

14. CPD NEEDS, ESCALATION OF POINTS FOR BOARD’S ATTENTION AND ANY OTHER
BUSINESS
14.1 After due discussion the AC concluded that all agenda items and supporting agenda papers had
received due consideration, that no significant training (Continued Professional Development – ‘CPD’) needs had been identified for AC members, and that no matters required escalation for the attention of the Board. There being no further AC business, RC closed the meeting.

15. DATES OF NEXT MEETINGS
15.1 The next quarterly meeting will be held on Tuesday 26th March 2013 starting at 09:00am in the
Boardroom, Maudsley Hospital, Denmark Hill. Meeting dates later in 2013 were covered in ST’s email of 13
December 2012 to AC members and attendees.
**ACTION POINT (‘AP’) LIST**
Excluded from the AP list below are actions previously agreed by the AC as completed and actions agreed by the AC Chair as completed.

‘GH’ action points. Whilst GH is in role as Acting Chief Executive his role as Director of Finance and Corporate Governance, and hence ‘GH’ action points noted below, are being covered on an interim basis by ND.

<table>
<thead>
<tr>
<th>Date arising</th>
<th>AC action point</th>
<th>Action lead</th>
<th>Date to complete</th>
<th>Notes/evidence that completed (or ref to relevant agenda item)</th>
<th>AC Chair sign off</th>
</tr>
</thead>
<tbody>
<tr>
<td>28.05.12 334</td>
<td>5.4.2 GH will update the AC about consolidation of the charitable funds and the impact on consolidation on SLaM’s accounts</td>
<td>“GH”</td>
<td>Jun.13</td>
<td></td>
<td></td>
</tr>
<tr>
<td>20.09.12 346</td>
<td>9.1.3 From now on each of Parkhill’s internal audit reports, and Progress Report summaries thereof will flag key changes (and expected changes that fail to occur) in circumstances, risks, assurance and management’s responses since the previous internal audit report</td>
<td>ML</td>
<td>Dec.12 Mar.13 onwards</td>
<td>Email from Parkhill 03.Dec.12. This AP will effectively apply from March ‘13 Progress Report onwards ... We will update as part of planned audit and follow-up work ...</td>
<td></td>
</tr>
<tr>
<td>20.09.12 347</td>
<td>9.3.2 Parkhill Computer Audit will deal with the remaining recommendations showing as unresolved since 2009 and 2010 (Progress Report Appendix 1 refers) and will reconcile and resolve the different priority ratings assigned by auditors and SLaM management</td>
<td>ML</td>
<td>Dec.12</td>
<td>Full update to be given at Mar.13 AC meeting. Email from Parkhill 03.Dec.12. IT Audit Follow-up report currently being quality checked and agreed with Trust management. Verbal update to be provided at AC meeting.</td>
<td></td>
</tr>
<tr>
<td>11.12.12 353</td>
<td>1.2 ST will schedule the following meetings into the AC’s workplan: (a) a private session (AC with DoF) every 6 months similar to that held 11.Dec.12; (b) CAG/service leaders (Mar.13, Jun.13 re data quality, and planning and management of changes, including commissioning); (c) GH, SM and LN (Mar.13 re Estates-related issues and lessons learned); and (d) LN (Jun.13 re effect of KHP and other changes on senior management</td>
<td>ST</td>
<td>Jan.13</td>
<td>ST emailed GH, SM, LN 13.Dec.12 re (c) and (d)</td>
<td></td>
</tr>
<tr>
<td>11.12.12 354</td>
<td>1.3 The AC will consider requesting ad hoc work from internal audit and/or others to enable the AC to give assurance/added value to the Board about outcomes, not simply process. ST will schedule this into the AC workplan</td>
<td>ST</td>
<td>Mar.13</td>
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<tr>
<td>11.12.12 355</td>
<td>7.1.2 JG will ask the SQIC Chair (HH): (a) to liaise with Cliff Bean and the Members’ Council (Noel Urwin) as soon as possible as regards the selection of a KPI for quality audit purposes; and (b) to flag to the Board key risks affecting quality of service over the next 3 to 4 years (due to the KHP process or otherwise)</td>
<td>JG</td>
<td>Dec.12</td>
<td></td>
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<tr>
<td>11.12.12 356</td>
<td>9.1.2 Deloitte will advise the AC of lessons learned by other clients re efficient and effective change management (with due regard to confidentiality)</td>
<td>MH</td>
<td>Jun.13</td>
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<tr>
<td>11.12.12 357</td>
<td>10.2.2 Parkhill will liaise, both formally and informally, with the internal auditors of other KHP partner bodies (and with ND who has general information from a recent seminar with Monitor and from commissioners) regarding impact of and risks around the KHP process. Parkhill and ND will report to the AC and/or the Board as appropriate</td>
<td>ML</td>
<td>Mar.13</td>
<td></td>
<td></td>
</tr>
<tr>
<td>11.12.12 358</td>
<td>12.4.2 Further to the results noted in section 4.1 of the risk monitoring report, JG will work with SLaM management to: (a) assess the adequacy of any alternative processes used by divisions with apparently poor compliance; and (b) report thereon to the SLaM executive and the AC</td>
<td>JG</td>
<td>Mar.13</td>
<td></td>
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</tr>
<tr>
<td>11.12.12 359</td>
<td>12.5.2 ND plans to present an integrated risk/performance/finance report to the Board in April 2013 (also covering relations with commissioners) and ND will ask the Board and AC to consider if that report can support or replace the Assurance Framework reports as currently presented to the Board and AC</td>
<td>ND</td>
<td>Jun.13</td>
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<tr>
<td>11.12.12 360</td>
<td>12.6.2 Every 6 months JG will test the Assurance Framework (as was done in agenda item 12.6) and report to the AC thereon</td>
<td>JG</td>
<td>Jun.13 onward</td>
<td></td>
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</tr>
<tr>
<td>11.12.12 361</td>
<td>12.6.3 JG will ask the SQIC to liaise as appropriate with other risk committees and to commission and consider reports on the apparently large numbers of off-ward suicide-related incidents shown by the serious incident report (agenda item 12.6), perhaps comparing with other Trust data</td>
<td>JG</td>
<td>Dec.12</td>
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<td>Number</td>
<td>Date</td>
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<td>Signature</td>
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<tr>
<td>93</td>
<td>13/07/2012</td>
<td>Deed of surrender, Form TR1 in respect of the Bloomfield Clinic, Guy’s Hospital, St Thomas Street, London (1 copy)</td>
<td>SLaM</td>
<td>Guy’s &amp; St Thomas’ NHS FT</td>
<td>Gus Heatfield</td>
</tr>
<tr>
<td>94</td>
<td>29/08/2012</td>
<td>Transfer deed (TR1) in respect of the sale of property at 8 Elepton Road, Streatham, SW16 2EJ (2 copies)</td>
<td>SLaM</td>
<td></td>
<td>Stuart Bell</td>
</tr>
<tr>
<td>95</td>
<td>29/08/2012</td>
<td>Transfer deed (TR1) in respect of the sale of property at 206 Selhurst Road, South Norwood, SE25 6XU (2 copies)</td>
<td>SLaM</td>
<td></td>
<td>Stuart Bell</td>
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<tr>
<td>96</td>
<td>28/09/2012</td>
<td>Settlement and variation agreement in respect of defects works at River House, Bethlem Royal Hospital (2 copies)</td>
<td>SLaM</td>
<td>Interserve Construction Ltd</td>
<td>Hilary McCallion</td>
</tr>
</tbody>
</table>
## Summary of Documents signed on behalf of the South London & Maudsley NHSFT where signing is required

<table>
<thead>
<tr>
<th>Number</th>
<th>Date</th>
<th>Description</th>
<th>Between</th>
<th>And</th>
<th>Signature 1</th>
<th>Signature 2</th>
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</thead>
<tbody>
<tr>
<td>229</td>
<td>13/07/2012</td>
<td>Clinical Trials Agreement in respect of the trial led by Dr James Bell MATTS ID 2183 (4 copies)</td>
<td>SLaM</td>
<td>King's College Hospital NHS FT</td>
<td>Louise Norris</td>
<td>Gus Heafield</td>
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<tr>
<td>230</td>
<td>13/07/2012</td>
<td>Agreement in respect of the provision of acute, ambulance, community and Mental Health and Learning Disability Services under the NHS Standard contract 2012/2013 (2 copies) plus 1 copy 2012/13 embedded document</td>
<td>SLaM</td>
<td>South of England Specialised Commissioning Group</td>
<td>Louise Norris</td>
<td>Gus Heafield</td>
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<td>231</td>
<td>13/07/2012</td>
<td>Learning and Development Agreement (2012/2013) in respect of the provision of Education and Training for the development of healthcare professionals (1 copy)</td>
<td>SLaM</td>
<td>London Strategic Health Authority</td>
<td>Hilary McCallion</td>
<td>Gus Heafield</td>
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<tr>
<td>232</td>
<td>13/07/2012</td>
<td>Clinical Trials Agreement relating to &quot;Double Blind 36 month, placebo controlled trial of mifepristone on cognition in alcoholics&quot; - Principal Investigator declaration Dr Jane Marshall (3 copies) (see entry 104 for main agreement)</td>
<td>SLaM</td>
<td>King's College London</td>
<td>Louise Norris</td>
<td>Gus Heafield</td>
</tr>
<tr>
<td>233</td>
<td>13/07/2012</td>
<td>Agreement to surrender in respect of the Bloomfield Clinic, Guy's Hospital, St Thomas' Street, London (1 copy) Form of Notice Declaration in respect of the above (1 copy)</td>
<td>SLaM</td>
<td>Guy's &amp; St Thomas' NHS FT</td>
<td>Gus Heafield</td>
<td>Louise Norris</td>
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<td>234</td>
<td>13/07/2012</td>
<td>NHS Jobs Agreement</td>
<td>SLaM</td>
<td>Secretary of State for Health</td>
<td>Gus Heafield</td>
<td>Louise Norris</td>
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<td>235</td>
<td>13/07/2012</td>
<td>Memorandum of Release Agreement in respect of 4A Dumbarton Road (1 copy)</td>
<td>SLaM</td>
<td>London &amp; Quadrant Housing Trust</td>
<td>Louise Norris</td>
<td>Gus Heafield</td>
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<td>236</td>
<td>27/07/2012</td>
<td>Policy Research Programme (PRP) Agreement in respect of the project entitled “Optimising identification, referral care of trafficked people within the NHS” (Ref: 115/0006 (2 copies) one signature required</td>
<td>SLaM</td>
<td>Secretary of State for Health</td>
<td>Gus Heafield (witness)</td>
<td>Stuart Bell</td>
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<td>237</td>
<td>27/07/2012</td>
<td>NIHR RfPB Grant (Ref: PB-PG-0211-24152) entitled &quot;Prevention of major depression in at-risk adolescents: a pilot randomised controlled trial of a screen and intervene program (2 copies) one signature required</td>
<td>SLaM</td>
<td>Secretary of State for Health</td>
<td>Stuart Bell</td>
<td>Gus Heafield (witness)</td>
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<td>238</td>
<td>27/07/2012</td>
<td>NIHR RfPB Grant (Ref: PB-PG-0711-25010) entitled &quot;Low intensity intervention to promote recovery in Psychosis: a pilot randomised controlled trial (2 copies) one signature required</td>
<td>SLaM</td>
<td>Secretary of State for Health</td>
<td>Stuart Bell</td>
<td>Gus Heafield (witness)</td>
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<td>239</td>
<td>27/07/2012</td>
<td>NIHR Programme Grant - sub contract in respect of research &quot;Towards an evidence based clinical management of visual hallucinations: prevalence, prognosis, impact and pathophysiology (2 copies) one signature required</td>
<td>SLaM</td>
<td>Newcastle University</td>
<td>Stuart Bell</td>
<td>Gus Heafield (witness)</td>
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<tr>
<td>240</td>
<td>27/07/2012</td>
<td>NIHR Programme Grant - sub contract in respect of research &quot;Towards an evidence based clinical management of visual hallucinations: prevalence, prognosis, impact and pathophysiology (2 copies) one signature required</td>
<td>SLaM</td>
<td>Northumberland Tyne and Wear NHS FT</td>
<td>Stuart Bell</td>
<td>Gus Heafield (witness)</td>
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<tr>
<td>241</td>
<td>27/07/2012</td>
<td>NIHR Programme Grant - sub contract in respect of research &quot;Towards an evidence based clinical management of visual hallucinations: prevalence, prognosis, impact and pathophysiology (2 copies) one signature required</td>
<td>SLaM</td>
<td>University Of Liverpool</td>
<td>Stuart Bell</td>
<td>Gus Heafield (witness)</td>
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<td>242</td>
<td>27/07/2012</td>
<td>NIHR Programme Grant - sub contract in respect of research &quot;Towards an evidence based clinical management of visual hallucinations: prevalence, prognosis, impact and pathophysiology (2 copies) one signature required</td>
<td>SLaM</td>
<td>Moorfield Eye Hospital NHS FT</td>
<td>Stuart Bell</td>
<td>Gus Heafield (witness)</td>
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<td>243</td>
<td>27/07/2012</td>
<td>NIHR Programme Grant - sub contract in respect of research &quot;Towards an evidence based clinical management of visual hallucinations: prevalence, prognosis, impact and pathophysiology (2 copies) one signature required</td>
<td>SLaM</td>
<td>UCL Institute of Ophthalmology</td>
<td>Stuart Bell</td>
<td>Gus Heafield (witness)</td>
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<tr>
<td>244</td>
<td>27/07/2012</td>
<td>NIHR Programme Grant - sub contract in respect of research &quot;Towards an evidence based clinical management of visual hallucinations: prevalence, prognosis, impact and pathophysiology (2 copies) one signature required</td>
<td>SLaM</td>
<td>King's College London</td>
<td>Stuart Bell</td>
<td>Gus Heafield (witness)</td>
</tr>
<tr>
<td>245</td>
<td>27/07/2012</td>
<td>NIHR Programme Grant - sub contract in respect of research &quot;Towards an evidence based clinical management of visual hallucinations: prevalence, prognosis, impact and pathophysiology (2 copies) one signature required</td>
<td>SLaM</td>
<td>University of Cambridge</td>
<td>Stuart Bell</td>
<td>Gus Heafield (witness)</td>
</tr>
<tr>
<td>246</td>
<td>27/07/2012</td>
<td>Clinical Trials Agreement in respect of CNS Experimental Medicine (4 copies) Form of indemnity(2 copies)</td>
<td>SLaM</td>
<td>Pivotal Ltd &amp; King's College London acting through Institute of Psychiatry</td>
<td>Stuart Bell</td>
<td>Gus Heafield (witness)</td>
</tr>
<tr>
<td>247</td>
<td>08/05/2012</td>
<td>NIHR Howard / Ffytche Programme Grant Agreement (1 copy) (see cross reference page entry after 219)</td>
<td>SLaM</td>
<td>Secretary of State for Health</td>
<td>Gus Heafield</td>
<td>Gus Heafield (witness)</td>
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<td>248</td>
<td>30/07/2012</td>
<td>Agreement for the provision of two female PICU inpatient beds for a period of 90 days from 30th July 2012 (1 copy)</td>
<td>SLaM</td>
<td>East London NHS FT</td>
<td>Gus Heafield</td>
<td>Louise Norris (witness)</td>
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<tr>
<td>249</td>
<td>06/08/2012</td>
<td>NIHR Contract in respect of Clinical Research Facilities for Experimental Medicine (2 copies) one signature required</td>
<td>SLaM</td>
<td>Secretary of State for Health</td>
<td>Martin Baggaley</td>
<td>Gus Heafield</td>
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<tr>
<td>250</td>
<td>06/08/2012</td>
<td>Memorandum of Understanding for the provision of Occupational Health &amp; Wellbeing services for a period of 3 years from 1st April 2012 (1 copy) one signature required</td>
<td>SLaM</td>
<td>King's College Hospital NHS FT</td>
<td>Martin Baggaley</td>
<td>Gus Heafield</td>
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<tr>
<td>251</td>
<td>07/08/2012</td>
<td>Clinical Trials Agreement in respect of the Rationalisation of antipsychotic drug use in older people using [18F] - Fallypride PET led by Dr Suzanne Reeves (3 copies)</td>
<td>SLaM</td>
<td>King's College London and Guy’s St Thomas’ NHS FT</td>
<td>Hilary McCallion</td>
<td>Zoe Reed</td>
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<tr>
<td>252</td>
<td>07/08/2012</td>
<td>Clinical Trials Agreement in respect of “A Pilot study of Concerta XL in adult offenders with ADHD” led by Professor Philip Asherson (3 copies)</td>
<td>SLaM</td>
<td>King’s College London</td>
<td>Zoe Reed</td>
<td>Hilary McCallion</td>
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## Summary of Documents delegated to Procurement

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<thead>
<tr>
<th>Contract number</th>
<th>Description</th>
<th>Supplier</th>
<th>Yearly contract value:</th>
<th>Contract Start</th>
<th>Extension Options</th>
<th>Contract signed by:</th>
<th>Budget sign off by:</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>Number</td>
<td>Date</td>
<td>Description</td>
<td>Between</td>
<td>Signature</td>
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<tr>
<td>97</td>
<td>12/10/2012</td>
<td>Sale Transfer Form TR1 in respect of the property at 183-185 Rushey Green,</td>
<td>SLaM</td>
<td>Martin Baggaley</td>
<td>Louise Norris</td>
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<td></td>
<td></td>
<td>Catford, London SE6 4BD</td>
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<tr>
<td>98</td>
<td>07/11/2012</td>
<td>Licence for works in respect of 88 and 90 Camberwell Road, London SE5</td>
<td>SLaM</td>
<td>John Roy Bloomfield</td>
<td>Gus Healfield</td>
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<td>253</td>
<td>24/09/2012</td>
<td>Clinical Trials Agreement in respect of &quot;A pragmatic randomised double blind trial of Antipsychotic treatment of very late onset schizophrenia like psychosis: The Atlas Trial&quot; (3 copies)</td>
<td>SLaM King's College London and Norfolk and Suffolk NHS FT</td>
<td>Louise Norris</td>
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<td>Clinical Trials Agreement in respect of &quot;A pragmatic randomised double blind trial of Antipsychotic treatment of very late onset schizophrenia like psychosis: The Atlas Trial&quot; (4 copies)</td>
<td>SLaM King's College London and Coventry &amp; Warwickshire NHS Partnership Trust</td>
<td>Gus Heafield</td>
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<td>256</td>
<td>24/09/2012</td>
<td>Research Contract in respect of The Attila Trial&quot; (HTA Project 10/55/02) (2 copies)</td>
<td>SLaM Secretary of State for Health</td>
<td>Gus Heafield</td>
<td>Louise Norris</td>
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<td>257</td>
<td>24/09/2012</td>
<td>NIHR Programme Grant Sub-Contract (REF: RP-PG-0707-10149) (CONMAN) (2 copies)</td>
<td>SLaM Birmingham &amp; Sollhull Mental Health NHSFT</td>
<td>Gus Heafield</td>
<td>Louise Norris</td>
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<td>258</td>
<td>24/09/2012</td>
<td>Sub-contract Agreement in respect of research services under the main contract for the NIHR Biomedical Research Centre and Research Unit (2 copies)</td>
<td>SLaM King's College Hospital NHS FT</td>
<td>Gus Heafield</td>
<td>Louise Norris</td>
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<tr>
<td>259</td>
<td>24/09/2012</td>
<td>Contract in respect of ICT Virtualisation and Storage Infrastructure Contract (2 copies) Call off Agreement in respect of this contract (2 copies)</td>
<td>SLaM Computacenter (UK) Insight Direct (UK) Ltd</td>
<td>Gus Heafield</td>
<td>Louise Norris</td>
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<td>260</td>
<td>24/09/2012</td>
<td>Agreement in respect of the &quot;SafeWards Trial&quot; led by Professor Len Bowers (1 copy)</td>
<td>Gus Heafield</td>
<td>Hilary McCallion</td>
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<td>261</td>
<td>24/09/2012</td>
<td>Service Level Agreement for Acute, Ambulance, Community and Mental Health Learning Disability Services (Bilateral) under 2012/2013 NHS Standard Contract (2 copies)</td>
<td>SLaM Richmond and Twickenham PCT</td>
<td>Gus Heafield</td>
<td>Louise Norris</td>
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<td>262</td>
<td>24/09/2012</td>
<td>Service Level Agreement for Acute, Ambulance, Community and Mental Health Learning Disability Services (Bilateral) under 2012/2013 NHS Standard Contract (2 copies)</td>
<td>SLaM Worcester PCT</td>
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<td>263</td>
<td>28/09/2012</td>
<td>Defects Works Information (volumes 1-7) forming part of the settlement and Variation Agreement in respect of defects at River House, Bethlem Royal Hospital (2 copies each of volumes 1-7) (see entry 96 in the sealed register for main settlement and Variation Agreement</td>
<td>SLaM Interserve Construction Ltd</td>
<td>Zoe Reed</td>
<td>Hilary McCallion</td>
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<td>264</td>
<td>04/10/2012</td>
<td>Clinical Trials Agreement in respect of the &quot;Mficog&quot; trial</td>
<td>SLaM King's College London and South West Yorkshire Partnership NHS FT</td>
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<td>265</td>
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<td>Clinical Trials Agreement in respect of the &quot;Benefit of Minocycline on Negative Symptoms in Psychosis&quot; led by Professor John Deaking (3 copies)</td>
<td>SLaM The University of Manchester and Manchester Mental Health and Social Care Trust</td>
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<td>266</td>
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<td>Clinical Trials Agreement in respect of &quot;A Pragmatic randomised double-blind trial of antipsychotic treatment of very late onset schizophrenia like Psychosis.&quot; &quot;The Atlas Trial&quot; led by Professor Rob Howard (2 copies)</td>
<td>SLaM</td>
<td>Louise Norris Gus Heafield</td>
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<td>267</td>
<td>04/10/2012</td>
<td>Clinical Trials Agreement in respect of the &quot;Effectiveness of Adoptive Opioid Agonist Maintenance Pharmacotherapy and Behavioural Therapies for Opioid Use Disorder&quot; (3 copies)</td>
<td>SLaM</td>
<td>Louise Norris Gus Heafield</td>
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<td>268</td>
<td>12/10/2012</td>
<td>Clinical Trials Agreement in respect of the &quot;Atlas Trial&quot; (3 copies)</td>
<td>SLaM</td>
<td>Martin Baggaley Louise Norris</td>
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<td>269</td>
<td>12/10/2012</td>
<td>Amended Settlement and Variation Agreement in respect of detects works at River House, Bethlem Royal Hospital (see entry no 96 sealed register for main settlement and Variation Agreement) (2 copies)</td>
<td>SLaM</td>
<td>Louise Norris Martin Baggaley</td>
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<td>270</td>
<td>22/10/2012</td>
<td>Clinical Trials Agreement in respect of the &quot;Atlas Trial&quot; (3 copies)</td>
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<td>272</td>
<td>22/10/2012</td>
<td>Clinical Trials Agreement in respect of the ADHD pilot led by Professor Asherson Addendum to the above Agreement (3 copies each of the main agreement and addendum)</td>
<td>SLaM</td>
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<td>273</td>
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<td>Funding Agreement letter dated 11th October 2012 for the clinical trial study led by Professor John Strang</td>
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<td>Martindale Pharma Louise Norris</td>
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<td>274</td>
<td>22/10/2012</td>
<td>Clinical Trials Agreement Amendment led by Dr Sukhi Shergill (REF: NN 25310) (4 copies)</td>
<td>SLaM</td>
<td>Gus Heafield Louise Norris</td>
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<td>275</td>
<td>22/10/2012</td>
<td>Clinical Trials Agreement Amendment led by Dr Sukhi Shergill (REF: NN 25307) (4 copies)</td>
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<td>276</td>
<td>22/10/2012</td>
<td>Contract in respect of the GPS Patient Monitoring Service for the period from 1st November 2012 to 31st October 2014 (2 copies)</td>
<td>SLaM</td>
<td>Buddi Ltd Louise Norris</td>
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<td>22/10/2012</td>
<td>NHF Research Contract in respect of the Programme Grant REF: PB-PG-0711-25106 (2 copies)</td>
<td>SLaM</td>
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<td>278</td>
<td>07/11/2012</td>
<td>Amendment to Clinical Trials Agreement in respect of the Cycle to Work scheme (2 copies)</td>
<td>SLaM</td>
<td>Louise Norris Gus Heafield</td>
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<td>279</td>
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<td>Collaboration Agreement in respect of the &quot;National Institute for Health Research/Wellcome Trust Clinical Research Facility at King's College Hospital NHS FT (4 copies)</td>
<td>SLaM</td>
<td>Louise Norris Gus Heafield</td>
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<td>280</td>
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<td>Clinical Trials Agreement in respect of the MATTs ID: 2513 trial led by Professor John Strang (2 copies)</td>
<td>SLaM</td>
<td>Gus Heafield Louise Norris</td>
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<td>281</td>
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<td>Louise Norris Gus Heafield</td>
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<td>282</td>
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<td>Clinical Trials Agreement in respect of the &quot;Atlas Trial&quot; (3 copies) led by Professor Robert Howard</td>
<td>SLaM</td>
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<td>Extension Options</td>
<td>Contract signed by</td>
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<tr>
<td>283</td>
<td>Contract Variation as co-ordinating commissioner for itself and as agent for and on behalf of the associates</td>
<td>SLaM</td>
<td>NHS Croydon</td>
<td>Gus Heathfield</td>
<td>Louise Norris</td>
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<td>284</td>
<td>Clinical Trials Agreement in respect of the &quot;Atlas Trial&quot; led by Professor Robert Howard</td>
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<td>King's College London and Cheshire and Wirral Partnership NHS FT</td>
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<td>Nick Dawe</td>
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<td>285</td>
<td>Clinical Trials Agreement in respect of the &quot;Atlas Trial led by Professor Robert Howard (3 copies)</td>
<td>SLaM</td>
<td>King's College London and North Staffordshire Combined Healthcare NHS Trust</td>
<td>Gus Heathfield</td>
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Summary of Documents delegated to Procurement
Date of Board meeting: Tuesday 22nd January 2013

Name of Report: Audit Committee (‘AC’) terms of reference (‘TOR’) for approval by the Board

Heading: - (Strategy, Quality, Performance & Activity, Governance, Information) Governance

Author: Steven Thomas (AC Secretary)

Approved by: Robert Coomber (AC Chair and Non Executive Director – ‘NED’)

Presented by: Robert Coomber (AC Chair and NED)

Purpose of the report:
To document the remit given to the AC by the Board

Action required:
Review the revised AC TOR presented

Recommendations to the Board:
Approve the revised AC TOR presented.

Relationship with the Assurance Framework (Risks, Controls and Assurance):
The AC’s role in relation to the Assurance Framework is one key subject covered in the TOR (section 3 refers)

Summary of Financial and Legal Implications:
No specific significant implications identified.

Equality & Diversity and Public & Patient Involvement Implications:
No specific significant implications identified.

Other key matters
1. In the revised TOR now presented for approval, references in the current approved TOR to the ‘Board Assurance Framework’ have been replaced with references to the ‘Assurance Framework’ to reflect current nomenclature. The AC meeting of 11 December 2012 considered that no further amendments were required to the current approved TOR, and that the revised TOR now presented are appropriate for Board approval.

2. The TOR were previously approved by the Board in 2011, and had been completely redrafted by the AC Chair, checked for consistency by the AC Secretary (including review against Monitor’s requirements for ACs as noted in the NHS Foundation Trust Code of Governance) and agreed by the AC as appropriate for the Board’s approval.

3. The AC is aware that the detailed form and content of the TOR depart from SLaM’s template committee TOR. However the AC considers that such departures are immaterial and are appropriate given the AC’s role.
Terms of Reference for Audit Committee (‘the Committee’)
Approved by Board of Directors [22 January 2013]
Next review: [January 2014] or sooner if appropriate

1 Composition
1.1 The Committee is a standing committee of the Board of Directors (‘the Board’) of South London and Maudsley NHS Foundation Trust (‘SLaM’) and is responsible to the Board. The Committee’s members are appointed by the Board from its non executive members. The Committee shall consist of at least three members of which one shall have relevant financial experience. The Board or the Chair of the Board will also appoint the Committee’s Chair.

2 Role of Committee
2.1 The overall role of the Committee is to promote the efficient and effective management of risk and excellent financial management and governance within SLaM. It will do this by putting in place arrangements:
   (a) generally to review and periodically report to the Board on the adequacy of the Assurance Framework and the associated systems and procedures which support it; and
   (b) specifically to monitor, review and periodically report to the Board on the adequacy of the financial systems and procedures used within SLaM.

3 Assurance Framework
3.1 The Assurance Framework is the strategic system for assessing, recording monitoring and managing all significant risks across SLaM. The role of the Committee is to ensure that risks are properly assessed, recorded and responded to in a manner which promotes the best possible use of resources and patient care and meets all appropriate governance and care standards.

3.2 The role of the committee is periodically to review the composition of the assurance framework in order to determine if it is both current and proportionate and to test the management systems which support it in order to assess the effectiveness and efficiency of risk management throughout SLaM.

4. Financial Assurance
4.1 The Committee shall have specific responsibility for ensuring that the principal systems and processes associated with financial management and financial governance within SLaM are efficient, effective and fit for purpose. These shall include:
   (a) internal control including arrangements for the prevention and detection of fraud and corruption;
   (b) internal audit;
   (c) external audit; and
   (d) financial management arrangements associated with resource planning, accounting, control, reporting and compliance.

4.2 The Committee shall review the annual financial statements (Trust accounts) and any formal public announcements related to financial performance before submission to the Board, focusing particularly on: (a) changes in, and compliance with, accounting policies and practices; (b) major judgemental areas; and (c) significant adjustments resulting from the audit.

5. Operation of the Committee
5.1 The Committee may investigate any activity within its terms of reference and will be given unrestricted access to SLaM’s employees, its records, and documentation except that relating to confidential patient information which will only be available on an exception need to know basis. The same access shall generally be afforded to internal and external audit.
5.2 One of the principal resources available to the Committee will be internal audit which will report to the Committee both formally and informally as required and independently when requested.

5.3 External Audit will also report to and advise the Committee within their statutory independent framework.

5.4 The Director of Finance and Corporate Governance will be responsible for ensuring that the Committee is kept informed of all significant financial risks, predicted changes in risk status and any significant weakness in SLaM's financial management arrangements.

5.5 The Committee may obtain outside legal or other independent professional advice and may secure the attendance of outsiders with relevant experience and expertise if it considers this necessary.

6. Internal Control and Risk Management

6.1 The Committee shall review the establishment and maintenance of systems and procedures associated with the management and control of SLaM's financial assets and liabilities in order to ensure that:

(a) those systems and procedures are efficient, effective and compliant with current legislative and national standards;

(b) those systems promote the detection and prevention of error, fraud or corruption; and

(c) financial regulations and procedures are current, relevant and complied with.

7. Internal Audit

7.1 The Committee will:

(a) in conjunction with the Director of Finance and Corporate Governance determine the appointment of the internal audit service, the audit fee and any questions of resignation and dismissal;

(b) review and approve the internal audit programme, consider the major findings of internal audit investigations and the adequacy of the management response. The Committee shall receive regular reports updating the Committee on the extent to which recommended changes have been implemented;

(c) ensure that the internal audit function is adequately resourced and has appropriate standing within the organisation; and

(d) annually assess the independence, objectivity, efficiency and effectiveness of the internal audit function.

8. External Audit

8.1 The Committee will:

(a) annually report to the Members' Council as to the performance of the external auditor (including details such as the quality and value of the work, and the timeliness of reporting and fees) to enable the Members’ Council to consider whether or not to reappoint the external auditor. The Committee will also make recommendations to the Members’ Council as to the appointment, reappointment, termination of appointment and fees of the external auditor and (if the Members’ Council rejects the Committee’s recommendations) prepare an appropriate statement for the Board to include in the Annual Report;

(b) review the annual audit program in conjunction with the external auditor and the Director of Finance and Corporate Governance;

(c) review external audit reports, including value for money reports and management letters, together with the management response, and the annual governance report (or equivalent);

(d) develop and implement policy on the engagement of the external auditor to supply non-audit services, taking into account relevant ethical guidance on this matter; and

(e) annually assess the independence, objectivity, efficiency and effectiveness of the external audit function.
9 Key Trust documentation
9.1 The Committee will review proposed changes to Standing Orders and Standing Financial Instructions for approval by the Board.

'10. Whistleblowing' arrangements
10.1 The Committee should review arrangements by which SLaM's staff may raise, in confidence, concerns about possible improprieties in matters of: financial reporting and control; clinical quality; patient safety; or other matters. The Committee should ensure that arrangements are in place for the proportionate and independent investigation of such matters and for appropriate follow-up action.

11 Frequency of Meetings
11.1 Meetings will be held at least four times a year. In addition, the Committee's Chair or the Board may convene one or more special meetings of the Committee. The external auditor or Head of Internal Audit may request a meeting if they consider that one is necessary.

12 Quorum
12.1 A quorum shall be two members.

13. Record Keeping
13.1 Archives of minutes and papers relating to Committee meetings are kept on SLaM's shared drive. The PA to the Director of Finance and Corporate Governance is responsible for maintaining the archive.

14 Other matters
14.1 Attendance at Committee meetings. All Committee members are expected to attend each Committee meeting. The Director of Finance and Corporate Governance, the Head of Internal Audit, the Local Counter Fraud Specialist (‘LCFS’) or a nominated representative and a representative of the external auditors shall normally attend meetings. Other members of the Board may attend if they wish. No other party may attend without the Committee’s specific invitation. The Committee has the overriding authority to restrict attendance at a meeting if the Committee considers this to be appropriate in the specific circumstances of that meeting.

14.2. Private meetings with auditors and LCFS. At least once a year the Committee may wish to meet with the external and internal auditors and LCFS without any executive Board director present. This is without prejudice to the unrestricted right of access to the Committee’s Chair by the external auditor and/or the Head of Internal Audit.

14.3. Liaison with Members’ Council. The Committee’s Chair will report to the Members’ Council: annually on the Committee’s work; and (if and as the Committee considers it necessary) on matters needing action or improvement, and the corrective steps to be taken.

14.4. Availability of terms of reference to the public. These terms of reference shall be made available to the public upon request and shall be included on SLaM’s website.

15 Chart of relationships to other meetings: (not applicable)
### 16. Revision log

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<thead>
<tr>
<th>Date</th>
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<tr>
<td>March 2005</td>
<td>Audit Committee Chair</td>
<td>Terms of Reference formally adopted by Board (of Directors).</td>
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<tr>
<td>September 2006</td>
<td>Audit Committee Secretary</td>
<td>Terms of Reference updated for recent DH guidance and approved by Audit Committee.</td>
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<tr>
<td>October 2006</td>
<td>Audit Committee Secretary</td>
<td>Terms of Reference reformatted to fit Trust template and approved by Board (of Directors).</td>
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<tr>
<td>December 2006</td>
<td>Audit Committee Secretary</td>
<td>Terms of Reference updated for Foundation Trust status (including Sep 06 Foundation Trust Code of Governance).</td>
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<tr>
<td>September 2007</td>
<td>Audit Committee Secretary</td>
<td>Update for changes in Chair and Members, and for minor style points.</td>
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<tr>
<td>June/July 2009</td>
<td>Audit Committee Secretary</td>
<td>Minor clarification, update and style revision, also reflecting a review against the Foundation Trust Code of Governance and the AC's review.</td>
</tr>
<tr>
<td>February 2011</td>
<td>Audit Committee Secretary</td>
<td>Update, reformatting and clarifications, also taking account of the latest current version of the Foundation Trust Code of Governance (March 2010 version) and the Bribery Act 2010.</td>
</tr>
<tr>
<td>December 2012</td>
<td>Audit Committee Secretary</td>
<td>References to the ‘Board Assurance Framework’ have been replaced with references to the ‘Assurance Framework’ to reflect current nomenclature. The AC meeting of 11 December 2012 considered that no further amendments were required and that the TOR were appropriate for Board approval.</td>
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<tr>
<td>Date</td>
<td>Report Deadline</td>
<td>Report Title</td>
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<td>26th Feb</td>
<td>Report Deadline Monday</td>
<td>Aramark Presentation</td>
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<td>Finance Report</td>
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<td>Service Quality Indicator Report</td>
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<td>Members Council Update</td>
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<td>Chief Executive Report</td>
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<td>Infection Control Report</td>
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<td>Service Quality Improvement Committee Minutes from February</td>
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<td>Members Council Update</td>
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