# AGENDA

<table>
<thead>
<tr>
<th>ITEM</th>
<th>General business</th>
<th>Purpose</th>
<th>Presented by</th>
<th>Category</th>
<th>Time</th>
</tr>
</thead>
<tbody>
<tr>
<td>-</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>1</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>3</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>4</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

## Objective: Enhancing Quality

<table>
<thead>
<tr>
<th>ITEM</th>
<th>General business</th>
<th>Purpose</th>
<th>Presented by</th>
<th>Category</th>
<th>Time</th>
</tr>
</thead>
<tbody>
<tr>
<td>5</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>6</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>7</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>8</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>9</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>10</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>11</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
## Agenda

### Objective: Sustainability

<table>
<thead>
<tr>
<th>No.</th>
<th>P</th>
<th>Title</th>
<th>Action</th>
<th>Duration</th>
</tr>
</thead>
<tbody>
<tr>
<td>12</td>
<td>P128</td>
<td>Business Committee report</td>
<td>To decide whether the contents of the report assure the board on the performance of the organisation</td>
<td>10 mins</td>
</tr>
<tr>
<td>13</td>
<td>P145</td>
<td>Infrastructure Committee report</td>
<td>To note the contents of the report and agree any proposals to ensure the trust meets its objectives</td>
<td>10 mins</td>
</tr>
<tr>
<td>14</td>
<td>P148</td>
<td>Digital Strategy</td>
<td>To agree the contents of the strategy</td>
<td>10 mins</td>
</tr>
</tbody>
</table>

### Objective: Workforce development and support

<table>
<thead>
<tr>
<th>No.</th>
<th>P</th>
<th>Title</th>
<th>Action</th>
<th>Duration</th>
</tr>
</thead>
<tbody>
<tr>
<td>15</td>
<td>P161</td>
<td>Workforce Committee report</td>
<td>To note the contents of the report and agree any strategic implications</td>
<td>10 mins</td>
</tr>
<tr>
<td>16</td>
<td>P165</td>
<td>Freedom to Speak Up Guardian Report</td>
<td>To note the report and consider proposed actions</td>
<td>5 mins</td>
</tr>
</tbody>
</table>

### Objective: Regulatory compliance

<table>
<thead>
<tr>
<th>No.</th>
<th>P</th>
<th>Title</th>
<th>Action</th>
<th>Duration</th>
</tr>
</thead>
<tbody>
<tr>
<td>17</td>
<td>P169</td>
<td>Audit and Risk Assurance report</td>
<td>To note the contents of the report and agree any proposals to ensure the trust meets its objectives and compliance requirements</td>
<td>10 mins</td>
</tr>
</tbody>
</table>

### Objective: Partnership

<table>
<thead>
<tr>
<th>No.</th>
<th>P</th>
<th>Title</th>
<th>Action</th>
<th>Duration</th>
</tr>
</thead>
<tbody>
<tr>
<td>18</td>
<td>P171</td>
<td>Board visits reports</td>
<td>Information relating to the experience of staff and patients and assess impact on delivery of trust objectives</td>
<td>5 mins</td>
</tr>
<tr>
<td>19</td>
<td>P184</td>
<td>Council of Governors update</td>
<td>To note the contents of the report and assess any impact on trust objectives and compliance.</td>
<td>5 mins</td>
</tr>
</tbody>
</table>
137th Meeting of the Board of Directors
10.30am, Thursday 9 January 2020
Maple Room
Pinewood House
Pinewood Place
DA2 7WG

AGENDA

<table>
<thead>
<tr>
<th>ANY OTHER BUSINESS</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>REVIEW EFFECTIVENESS OF MEETING</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>DATE OF NEXT MEETING</th>
</tr>
</thead>
<tbody>
<tr>
<td>The next Board of Directors Meeting will take place on:</td>
</tr>
<tr>
<td>Thursday 5 March 2020 at 10.30am</td>
</tr>
<tr>
<td>Maple Room, Pinewood House</td>
</tr>
</tbody>
</table>
# Report Title
Minutes of the Board of Directors Meeting held on 7 November 2019

## Author
Susan Owen, Risk and Governance Manager

## Accountable Director
Andy Trotter, Chair

## Confidentiality/FOI status
Public

## Report Summary
Minutes of the Board of Directors meeting held on 7 November 2019

## Purpose
- **Information**
- **To Note**

## Approval
- **√**

## Decision

## Recommendation
The Board agrees the minutes as a true record of the meeting.

## Link to strategic objectives
<table>
<thead>
<tr>
<th>Quality</th>
<th>Workforce</th>
<th>Sustainability</th>
<th>Partnerships</th>
</tr>
</thead>
</table>

## Link to Board Assurance Framework
N/A

## Implications
- Quality
- Financial
- Equality analysis
- Service user/carer/staff
136th Meeting of the Board of Directors  
Minutes of the meeting held on Thursday 7 November 2019  
Maple Room, Pinewood House

**Board of Directors**  
Steve Dilworth  Acting Chair  
Steve James  Non-executive Director  
Jo Stimpson  Non-executive Director  
Yemisi Gibbons  Non-executive Director  
Dr Amlan Basu  Non-executive Director  
Matthew Trainer  Chief Executive  
Ify Okocha  Medical Director and Deputy Chief Executive  
Jane Wells  Director of Nursing  
Michael Witney  Director of Therapies  
Jazz Thind  Director of Finance

**In attendance**  
Sally Bryden  Trust Secretary and Associate Director of Corporate Affairs  
Keith Soper  Director, Forensic and Prison Services (attending for Iain Dimond)  
Debbie Wheddon  Associate Director, Workforce and Organisational Development  
Susan Owen  Risk and Governance Manager (minutes)

**Members of the Council of Governors in attendance**  
Jo-Anne Linnane  Staff: Children and Young People  
Tina Strack  Service user/carer: Bexley Adult

**CQC observers**  
Judith Edwards  Care Quality Commission  
Hannah Wightman  Care Quality Commission

Prior to the formal meeting, the Board of Directors received a presentation from colleagues at HMP Wandsworth.

<table>
<thead>
<tr>
<th>Item</th>
<th>Subject</th>
<th>Action</th>
</tr>
</thead>
<tbody>
<tr>
<td>1a</td>
<td>Questions from the public</td>
<td>Noted</td>
</tr>
</tbody>
</table>

*Given that conditions at HMP Belmarsh have been well-reported in the media, especially the recent report by the Independent Monitoring Board, how has Oxleas NHS Trust Board responded to date and what further actions are planned with regard to healthcare and public health issues?*

*Has the service been sub-contracted, who to and for how long?*

KS - Services are commissioned by NHS England and the prisons are partners in co-commissioning. We have two years left on the Greenwich cluster contract. This was a five year contract with the option to extend for a further two years. This is standard practice. We deliver primary care services and mental health services. We sub-contract GP services and this is delivered in conjunction with Oxleas nursing services. We also sub-contract some part-time services such as podiatry, speech and language therapy and substance misuse. A full range of services are available including pharmacy, dentistry and optometry. Some sites now have x-ray facilities. We aim to provide as much as possible on site. HMP Belmarsh, HMP Thameside and HMP Wandsworth have in-patient units and this is required to be equivalent to services in the community. For specialist care, prisoners are referred to acute trusts. Environmental factors can be a barrier. This can impact on the level of engagement, so we provide other means of accessing healthcare behind cell doors. The placement in the prison is the decision of the prison authority and the trust cannot get involved in this. This can mean that on occasion people are in healthcare but there is no primary healthcare need. For example, in HMP Wandsworth there is a shortage of
<table>
<thead>
<tr>
<th>Item</th>
<th>Subject</th>
<th>Action</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>disabled cells so prisoners reside within the in-patient unit. The independent report is just one way we get feedback. We are also subject to other inspections by the CQC and HMIP. There was no enforcement action from last inspection. <strong>Given that Oxleas NHS Trust is the service provider commissioned by NHS England to provide healthcare services for HMP Belmarsh have all the Board of Directors been made aware of the following documents? Has the Board addressed the implications of the conditions revealed in those reports for the provision of healthcare services at HMP Belmarsh?</strong> SD – KS has touched on partnership working. We receive information from a range of sources and any significant issues would be brought to our attention. We visit the prisons so we can see services at first hand. Any information we get from NHSI would be fed back to the board via the Performance and Quality Assurance Committee. <strong>How has Oxleas NHS Trust responded to the Royal College of Physicians guidelines for healthcare professionals working with victims of torture in detention in the following areas?</strong> KS – We have a trauma informed model and staff are trained to recognise people who have been subjected to abuse or torture. We are experienced in dealing with this and there is a range of therapeutic responses in place. We understand that incarceration has a damaging effect on an individual. Our position is that we are provider of health care, and our records are separate to prison custody records. We do not get involved in discipline matters and vice versa as health records are confidential. Every prisoner has a first night reception screen and a more detailed assessment within 48 hours. A detailed care plan is devised and delivered. Length of stay can range from a few days in remand to several years. MT – The extent to which the prison regime influences health care delivery is an interesting dynamic. We directly employ approximately 600 staff in prisons and another 300 to 400 are sub-contracted on a sessional basis. The assessment rate is very high and there is a high caseload. We have an impressive group of staff working in a challenging environment with vulnerable individuals. <strong>How has Oxleas NHS Trust, as the service providers for HMP Belmarsh, responded to the report by the UN Rapporteur on Torture on the continued detention of XX?</strong> In terms of XX’s fitness for trial and ability to have a fair trial, does the health service have any influence on this and can the medical community make statements? KS – We cannot comment on individuals. Routinely, if there was a question on fitness for trial, an appropriate decision would be sought from psychiatrist. Every person who enters the prison has their needs addressed and an individual plan of care developed. <strong>Action: KS to provide written response within two weeks, and offer a meeting with colleagues from prison healthcare.</strong> The written response is attached.</td>
<td></td>
</tr>
</tbody>
</table>

1b Apologies for absence  
- Andy Trotter, Trust Chair  
- Nina Hingorani, Non-executive Director  
- Suzanne Shale, Non-executive Director  
- Iain Dimond, Chief Operating Officer  
Declarations of interest  
- AB declared that he is the medical director of an independent provider. There are no specific conflicts in relation to the topics being discussed at today’s meeting.  

2 Minutes of last meeting  
**Page 4, item 8:** Clarify that the visit to Greenwood was a food hygiene visit. Add an action that the trust will confirm if there are any other Oxleas sites where such visits take place and similar issues have been raised.  
**Page 4, item 9:** Add an action that the outcome of the discussion on anti-ligature works to be reported to the Board. Pending these amendments, the minutes of the meeting on 5 September 2019 were **Approved**  

- 2019-11/#1 KS  
- 2019-11/#2 ID  
- 2019-11/#3 JW
<table>
<thead>
<tr>
<th>Item</th>
<th>Subject</th>
<th>Action</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>approved as an accurate record.</td>
<td></td>
</tr>
<tr>
<td>3</td>
<td>Matters arising</td>
<td>Noted</td>
</tr>
<tr>
<td></td>
<td><strong>Item 13:</strong> The ratio of patient and non-patient facing staff is approximately 80:20, and further work is being undertaken to understand the detail. JT said that the 20% includes administrative staff supporting clinical teams, and the numbers would shift if they were to be presented differently.</td>
<td></td>
</tr>
<tr>
<td></td>
<td><strong>Action tracker</strong></td>
<td></td>
</tr>
<tr>
<td></td>
<td>2019-09/#02: A review of board oversight of health and safety is in progress. This will be explored further at the next board strategy day.</td>
<td></td>
</tr>
<tr>
<td></td>
<td>2019-07/#01: An update on SARD will be presented to the Business Committee in December 2019, and will subsequently be presented to the board.</td>
<td></td>
</tr>
<tr>
<td></td>
<td>2019-09/#01: The PAS review remains in process. This will be reported to the Board of Directors in January 2020.</td>
<td></td>
</tr>
<tr>
<td>4</td>
<td>Board Assurance Framework</td>
<td>Noted</td>
</tr>
<tr>
<td></td>
<td>The Board of Directors noted the Board Assurance Framework. The following exceptions were noted.</td>
<td></td>
</tr>
<tr>
<td></td>
<td>1291: There is a risk that we will not achieve 100% of the CQUIN value. This could result in a loss of income. For 2019/20 this is £1.0m, which equates to approximately 50% of CQUIN income.</td>
<td></td>
</tr>
<tr>
<td></td>
<td>The main area of concern is the uptake of the flu vaccine. There has been a high demand and we are waiting for further supplies to be delivered. We are making good progress and we are ahead of our target for the same time last year.</td>
<td></td>
</tr>
<tr>
<td></td>
<td>1695: Patients and staff at Greenwich Square may be compromised because we are operating out of a building where there are identified fire safety concerns</td>
<td></td>
</tr>
<tr>
<td></td>
<td>The area of concern noted by the Infrastructure Committee was that our landlords have not provided evidence of statutory compliance for the whole building. This is being followed up the Director of Estates. JT said that the executive will need to give the landlord clear timescales to produce this documentation. The CCG have been informed. The risk is to be re-worded to reflect this.</td>
<td></td>
</tr>
<tr>
<td></td>
<td>1606: The trust continues to rely on non-Oxleas beds (NHS and non-NHS) to manage demand on in-patient services and the changes associated with the MHA; the greatest pressure is in Greenwich. If the trust is not able to reduce demand through the deployment of admission avoidance strategies, this will continue to create a cost pressure and impact on the overall financial position of the Trust</td>
<td></td>
</tr>
<tr>
<td></td>
<td>As of yesterday, there were eight UEA placements. The pressures are greatest in Greenwich, so weekly meetings are taking place. MT said this is a supportive process and teams have responded well. The pressure in emergency departments is reflected in our HTT caseloads. We are retaining a locum as an additional resource. The main issue is in CMHTs, as teams are over-stretched.</td>
<td></td>
</tr>
<tr>
<td></td>
<td>1565: The STP expects organisations within the SEL footprint to take on a collective responsibility in identifying further opportunities (over and above those factored into operational plans) to address the financial difficulties within the system. Current net STP collective ‘constrained’ gap equates to £74m. All individual organisations within the STP need to support the changes required to improve financial performance and may be asked to take part in financial risk/gain shares that incentivise the right behaviour to close the gap</td>
<td></td>
</tr>
<tr>
<td></td>
<td>SD – Does the risk description needed to be revisited?</td>
<td></td>
</tr>
<tr>
<td></td>
<td>JT - This has been discussed at STP meetings, and this remains a challenge. We do need to</td>
<td></td>
</tr>
<tr>
<td>Item</td>
<td>Subject</td>
<td>Action</td>
</tr>
<tr>
<td>------</td>
<td>---------</td>
<td>--------</td>
</tr>
<tr>
<td>5</td>
<td>Temporary board arrangements</td>
<td>Approved</td>
</tr>
<tr>
<td></td>
<td>Whilst AT is on a temporary leave of absence, SD will be the acting chair. It was proposed that SJ will be the Acting Vice Chair and Chair of the Audit and Risk Assurance Committee, and that AB will join the Audit and Risk Assurance Committee as the third NED member. These arrangements were approved by the Board of Directors.</td>
<td></td>
</tr>
<tr>
<td>6</td>
<td>Chief Executive Report</td>
<td>Noted</td>
</tr>
<tr>
<td></td>
<td>Mental health compact: A diagnostics report is to be circulated. This will focus on one week of attendances, breaches due to bed availability and Approved Mental Health Professionals (AMHPs). A current challenge is that AMHPs do not work across borough boundaries; this is a custom and practice issue. We are considering if we can create a bursary to train other professionals as AHMPs; traditionally there are social workers. SLP acute board: Coding suggests that some referrals are coded incorrectly, for example, mental health patients presenting with physical health problems at EDs. District nursing celebration: We have set up a special event to celebrate district nursing in South East London which will take place later this month. Silver Award – Armed Forces Covenant: We have been awarded the Silver Award in the Ministry of Defence Employer Recognition Scheme marking. QI events: The South London Partnership Quality Improvement Conference 2019 will take place on 21 November at KIA Oval, Kennington. This will include presentations on Quality Improvement projects across all three trusts. Black History Month: A highly successful event was held in October with presentations from powerful speakers. Trust leadership developments: Dr Abi Fadipe and Dr Tom Clark have been appointed to the role of joint Deputy Medical Director. Dr Fadipe is currently Clinical Director for our Bromley services and Dr Clark will join us from the Princess Royal University Hospital. Dr Clark is due to start with the trust on 13 January 2020. Rachel Clare Evans will join the trust as Director for Strategy and People from 18 November 2019. Nursing Development Programme: We have agreed to fund a number posts to support nursing development and this should enable us to make savings. JS – On a visit to Highpoint House, I heard that teams struggle with waiting times and outcomes. We need to be more creative as to how we reconfigure services. AB – The coding of ED patients is a symptom of the stigma associated with mental health. I am supportive of having mental health professionals in the EDs as this will help to change the culture.</td>
<td></td>
</tr>
<tr>
<td>7</td>
<td>Integrated performance dashboard report</td>
<td>Noted</td>
</tr>
<tr>
<td></td>
<td>The five areas of exception are: 1) 48 hours post-discharge follow-up; 2) 30 day target for responding to complaints; 3) performance against outstanding actions from complaints; 4) mental health FFT; and 5) prison vacancies, where the two spikes relate to acquiring different services. It is anticipated that this will be back on track within six months. MW – We are working through how to present complaints information in a more useful way, so as to provide a more robust understanding and a more reliable view. JS – What are the issues in Greenwich with regard to 48 hour follow-up? KS – Five appointments were missed but there were no specific reasons. The history of the data shows that this is not completely uncommon. The process is to use an i-Fox prompt, with the Business Office checking on a daily basis. JS – It is important that the wards use i-Fox System. MT – There are a number of items that we ask ward managers to check. We need to consider how we support them and avoid putting managers under additional pressure.</td>
<td></td>
</tr>
<tr>
<td>Item</td>
<td>Subject</td>
<td>Action</td>
</tr>
<tr>
<td>------</td>
<td>---------</td>
<td>--------</td>
</tr>
<tr>
<td>JS –</td>
<td>There needs to be a rationalisation of understanding what is important, defining responsibilities and making sure that people have the right tools and skills.</td>
<td></td>
</tr>
<tr>
<td>IO –</td>
<td>We need to encourage a system that the clinical charge nurse (band 6) takes on some of these responsibilities. We need to have a programme of training and support in place.</td>
<td></td>
</tr>
<tr>
<td>JW –</td>
<td>We have implemented a successful band 6 development programme. Staff were being promoted and retaining some tasks, rather than delegating back down. We need to ensure that ward managers and band 6 staff are working together.</td>
<td></td>
</tr>
<tr>
<td>JS –</td>
<td>Demand is increasing, set against block contracts and efficiency targets. We need to consider how we structure teams to be clear on roles. We need to recognise that we may need to go into deficit in order to deliver a quality service.</td>
<td></td>
</tr>
<tr>
<td>MT –</td>
<td>We need to have a stronger savings programme, aligned to making decisions on quality.</td>
<td></td>
</tr>
<tr>
<td>JT –</td>
<td>We need to focus on where we are over-spending and bring this back into balance. We need to consider where money would be best utilised.</td>
<td></td>
</tr>
</tbody>
</table>

8 *Operational Service Report*

Service directorates were asked to set out challenges in relation to 1) demand and capacity, impact on waits, access to CAMHS, PCP in Bromley; 2) workforce and recruitment, including the impact on smaller community teams and the sustainability of services; 3) the implications and impact of commissioning and tendering.

SD – Is there any feedback in relation to the closure of Bluebell House?

KS – We have made a commitment to facilitate access to alternative services. Staff consultation meetings are taking place and staff will be offered suitable alternative employment. Staff understand that this was not an Oxleas decision.

SJ – In relation to ALD services, there has been another national report on secure accommodation. This might impact the SLP. We should consider what we can contribute across south east London. At the Bexley Care Business meeting there was a discussion on rationalising some of teams and it would be useful to have feedback on the progress being made on this. We need to consider how we use specialists more effectively and collate evidence of the impact of this.

KS – Our aim is to provide a better range of treatment options. A specialist forensic learning disability team is in place. This forms part of our business case for adult secure services, and there are other developments that we want to make in these areas.

JS – When will the work we are undertaking with the ED at QEH be part of structure?

MT – I am meeting with LGT to discuss this.

IO – There are challenges on what the model will be.

JS – How can we challenge this at STP level?

MT – Staff at QEH are reacting well to pressures. All EDs are facing challenges at present.

9 *Business Committee report*

We are £0.6m behind plan and we are releasing money to cover this. The two factors influencing this are external beds, and the fact that we are not yet close to achieving planned CRES.

JT – The main challenges are achieving savings and managing overspend. There are challenges to selling theatre space on the QMH site and we are developing a specification for this.

SD – It positive to see that the reduction of agency spend has been sustained.

JT – This is last the year when the sustainability fund will be available, so we are maximising the opportunity this year.

10 *Charitable Funds Accounts and Annual Report 2018/19*

JT presented the Charitable Funds Accounts and Annual Report for 2018/19; these have been fully consolidated into the Trust group accounts. The Board of Directors are the Corporate Trustee of the Charitable Funds, and are required to approve the accounts and provide oversight of spend. The accounts were presented to the Audit and Risk Assurance
Committee on 17 September 2019, where it was agreed to recommend to the Corporate Trustee that the Charitable Funds Accounts and Annual Report for 2018/19 are approved.

The Executive Team and the Business Committee have agreed the following proposals:

- To consolidate the current 55 funds to 33 funds through the amalgamation of 26 unrestricted funds and by creating four new general funds, including three borough funds.
- That the balance of £282.12 held in a restricted fund for Centrepieces Mental Health Art Project (which now operates through a separate registered Charity of the same name) is transferred to the Centrepieces Mental Health Art Project and the charitable fund held under Oxleas NHS Foundation Trust Charitable Fund is closed.
- To continue to work with the Charities Commission to review the status of restricted funds.

It was noted that the trust opted to have the accounts reviewed as an independent examination by Grant Thornton, and that this examination confirmed that there are no material matters arising from the review.

The Board of Directors as the Corporate Trustee approved the Oxleas NHS Foundation Trust Charitable Fund Accounts, Report and Letter of Representation for 2018/19. The three proposals above were also approved.

11 Infrastructure Committee report

The committee reviewed the Capital Plan. It was noted that estimated costs are different to actual costs. With regard to ligature points in older peoples in-patient wards, there will need to be a discussion amongst clinicians as to what our position should be. Wards will need to be dementia friendly, so there needs to be a balance of risk.

JT – The sale of Rowan House has completed. There will be a profit on sale, but we cannot use this towards our control total.

12 Performance and Quality Assurance Committee report

The PQAC received a presentation from the Children and Young Persons directorate, which included a discussion on waiting times for assessments. The Forensic and Prisons Directorate presented reviews of substance misuse, violence and aggression and physical health management. The committee has also undertaken an in-depth review of the Friends and Family Test (FFT). There has been a general decline in performance, so it was useful to have a discussion on how we will address this going forward.

SD – Do the comments relating to the CQC visits to HMP Cookham Wood and HMP Stanford Hill relate to both sites?

KS – Positive verbal feedback was received for both visits. We do not have the final reports yet. At HMP Cookham Wood we provide primary care only. The services at HMP Stanford Hill are very small.

MW – In relation to the FFT, the phrasing of the question will change and this will be a more useful measure.

JW – There has been one new Level 5 incident relating to the unexpected death of a 43 year old discharged from Goddington Ward. I will chair the enquiry.

KS – There were two deaths in custody at HMP Swaleside at weekend; these appear to be linked to substance misuse. The prison went into lockdown as a result. All prisoners have been advised of the implications. There will be coroner’s inquests and PPO investigations. The 72 hour reports have been completed. Neither patient was under active case management.

AB – With respect to clinical effectiveness and care planning, we will need to make a distinction between audit participation and the quality of the care plan/ communication with users.
<table>
<thead>
<tr>
<th>Item</th>
<th>Subject</th>
<th>Action</th>
</tr>
</thead>
<tbody>
<tr>
<td>IO –</td>
<td>We know that more people are participating and the results are improving. There are some areas where we need to do better, such as service user involvement and the support network. Each team should discuss how the audit can be used to make improvements.</td>
<td></td>
</tr>
<tr>
<td>YG –</td>
<td>It would be useful to include the minutes as an appendix to add this context.</td>
<td></td>
</tr>
<tr>
<td>SJ –</td>
<td>We are making good progress on understanding that quality is not driven by data alone. We need to get the balance right and the strategy development work gives us an opportunity to do this.</td>
<td></td>
</tr>
<tr>
<td>13</td>
<td><strong>Mortality Surveillance Committee report</strong></td>
<td></td>
</tr>
<tr>
<td>The board noted the quarter 1 report from the Mortality Surveillance Committee. Reviews into 221 deaths have been completed, the majority of which relate to natural causes. We continue to build on LEDER learning, and an update will be brought to the board in January 2020. We have taken on board the learning from Berkshire Healthcare NHS Foundation Trust, and this will also be a focus for National Patient Safety Week. A resuscitation officer has been recruited for one year and this will make a difference on enhancing training.</td>
<td>Noted 2019-11/#4 JW</td>
<td></td>
</tr>
<tr>
<td>SD –</td>
<td>How have we changed our thinking on supporting bereaved families?</td>
<td></td>
</tr>
<tr>
<td>JW –</td>
<td>We are mindful of this and sensitive work is taking place.</td>
<td></td>
</tr>
<tr>
<td>YG –</td>
<td>It is good to see learning from thematic reviews, but there is an emerging trend on people taking their lives on return from leave. Do we have plans in place to look back on these cases?</td>
<td></td>
</tr>
<tr>
<td>JW –</td>
<td>The numbers are very small. There are robust procedures in place and there is now a heightened awareness and vigilance. We always reinforce the learning. We have looked at serious incidents close to point of discharge to see if there was learning, but nothing was identified in terms of practice improvements.</td>
<td></td>
</tr>
<tr>
<td>IO –</td>
<td>We are reviewing other indicators that clinicians should be looking for.</td>
<td></td>
</tr>
<tr>
<td>MT –</td>
<td>The Cavendish Square Group is working towards reducing the suicide rate in London and I will feedback on this.</td>
<td></td>
</tr>
<tr>
<td>14</td>
<td><strong>Infection prevention and control annual report</strong></td>
<td></td>
</tr>
<tr>
<td>This has been a very positive year, with low infection and outbreak rates. We have maintained performance in audits and policy reviews. Areas of focus are catheter care, microbial support and investigating incidents.</td>
<td>Noted</td>
<td></td>
</tr>
<tr>
<td>SD –</td>
<td>What are the outcomes for assurance purposes?</td>
<td></td>
</tr>
<tr>
<td>JW –</td>
<td>We collect data and we have taken learning from this.</td>
<td></td>
</tr>
<tr>
<td>JS –</td>
<td>We have issues at QMH with regard to water safety. Do we need to be more demanding of our contractors and encourage a zero tolerance approach?</td>
<td></td>
</tr>
<tr>
<td>JW –</td>
<td>Legionella risks are well managed at QMH. Water is flushed regularly where outlets are not used on a regular basis.</td>
<td></td>
</tr>
<tr>
<td>SJ –</td>
<td>We should acknowledge that this is a good report and thank the team behind this.</td>
<td></td>
</tr>
<tr>
<td>15</td>
<td><strong>Mental Health Law Annual Report</strong></td>
<td></td>
</tr>
<tr>
<td>This has been presented to the Executive Team and the Mental Health Legislation Oversight Group. The report highlights trends and exceptions. A need to improve recording on RiO has been identified. Section 136 has been a significant issue of focus. Liberty Protection Safeguards (LPS) will replace Deprivation of Liberty Safeguards (DOLS) in October 2020, and awareness session has been arranged for 6 December 2020.</td>
<td>Noted</td>
<td></td>
</tr>
<tr>
<td>SJ –</td>
<td>We will need to ensure that we are prepared in advance for LPS. We have a good focus on s136 and the number of breaches remains low. There needs to be a London wide focus, and we need to push for a response. We should acknowledge the contribution of the Hospital Managers, who undertake complex and stressful MHA work on behalf of the trust.</td>
<td></td>
</tr>
<tr>
<td>YG –</td>
<td>The Performance and Quality Assurance Committee is also sighted on this.</td>
<td></td>
</tr>
<tr>
<td>16</td>
<td><strong>Quality Improvement and Innovation Committee report</strong></td>
<td></td>
</tr>
<tr>
<td>The Quality Improvement and Innovation Committee received presentations from Greenwich CAMHS and the CASH service, which showed good examples of success.</td>
<td>Noted</td>
<td></td>
</tr>
<tr>
<td>Item</td>
<td>Subject</td>
<td>Action</td>
</tr>
<tr>
<td>------</td>
<td>---------</td>
<td>--------</td>
</tr>
</tbody>
</table>
| Care have not undertaken as many projects as other directorates, but there are clear reasons for this.  
YG – It has also been beneficial to understand where projects have not worked well.  
SD – Only 22% of projects include service user involvement.  
SJ – This is improving. Our initial focus was on getting staff involved.  
MT – A step-change is required to achieve this.  
MW – We are learning from ELFT on how they have incorporated user involvement across their organisation. | Noted |
| **17 Workforce Committee report**  
The committee received an update on WRES initiatives; some of these remain a work in progress. We are performing well against KPIs. A workplan is in place to support junior doctors. There is more work to be undertaken on the apprenticeship levy and accessing funding and this remains an area of challenge. There had been an increase in FTSU concerns being raised, but this has now stabilised. By the end of the calendar year, the trust will have moved to an independent service. It was noted that there has been a decline in the number of reactive counter fraud referrals, and this is being reviewed by our Local Counter Fraud Specialist (LCFS). | Noted |
| **18 Medical Revalidation and Appraisal Annual Report**  
The board noted the Medical Revalidation and Appraisal Annual Report. Oxleas performs well compared to other sectors, but we need to consider succession planning. | Noted |
| **19 Audit and Risk Assurance Committee report**  
Grant Thornton (GT) provided a response to the recent Financial Reporting Council (FRC) criticism of audit firms. The committee received assurance that GT has plans in place to address this and the committee was assured of the quality of their work. The committee received a comparison of our Board Assurance Framework (BAF) against similar trusts in London and the south east of England. The top themes across all trusts are financial challenges and staff recruitment and retention. Many of our neighbours have BAF risks relating to the delivery of ICT and estates strategies, data accuracy and CQC compliance monitoring. These risks do not currently appear on our BAF, but have done so in the past. It was noted that consultant who reviewed our BAF as part of the CQC preparation had commented that we had a good balance of strategic risks. The committee noted that charitable funds donations should ideally be spent within two years.  
JT – The consolidation of funds will enable these commitments to be made. We need to consider how we can make our charity more visible. We can promote this as part of the strategy work.  
SB - Staff assemblies are to be engaged to support this.  
MT – SLAM are undertaking work on fundraising and there is learning to be gained from this, including the opportunity for shared posts. | Noted |
| **20 Board visits reports and review of visit action tracker**  
The board noted the six month update on actions being taken forward. 25 out of 256 actions remain open. These tend to relate to cultural or estates issues which take longer to resolve.  
JS – Acorns: In other directorates, 16-18 year old MSK patients fall under adult services. The environment is designed for younger children, so this is not working for staff or service users.  
SJ – CART: This is a good team, but overwhelmed. Referrals need to be responded to more quickly. The team need to have a clear specification as to the services they deliver, and they will need support to develop this. It would be easier for them to deliver a quality service if this was more defined. MW said that the triage post in the Central Access Team should be filtering this, but there are challenges with recruiting band 6 physiotherapists.  
MT said that we have small teams, so some of jobs are not attractive. Staff members had | Noted |
<table>
<thead>
<tr>
<th>Item</th>
<th>Subject</th>
<th>Action</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>good ideas on how we review posts, for example consolidating vacancies into higher banded posts. SJ said that there are concerns with how referrals are managed by the SPA and that too much time is spent on this. IO said that this will be followed up. MW – HMP Wandsworth: This was a good visit, but there is more work to do with AHPs. JW – Shepherdleas Ward: This was a good visit. JS – Bexley CAMHS: This was a good team, however signage on the site not clear. MT said that there are longer term plans for the Erith site. MW – HMP Swaleside: The distance from other services makes this site feel remote, but staff are motivated and feel connected with Oxleas. SD – Can You Understand It Group: This is a very committed group and a commendable service. JT said that the membership includes a broad spectrum of patients. IO said that there are good group dynamics. JS – Highpoint House: Staff raised concerns that there is no zebra crossing across Shooters Hill Road. It was noted that Rachel Evans is following this up with RBG.</td>
<td></td>
</tr>
<tr>
<td>21</td>
<td>Council of Governors update</td>
<td>Noted</td>
</tr>
<tr>
<td></td>
<td>The report from the Council of Governors was noted. The Annual Members Meeting was well attended, and this was a positive event. Governors have visited the Bexley Single Point of Contact team. New governors have attended their induction. JL said that the community engagement event provided a good opportunity to network with other services and raise the profile of the services we offer.</td>
<td></td>
</tr>
<tr>
<td>22</td>
<td>Any other business</td>
<td>Noted</td>
</tr>
<tr>
<td></td>
<td>MT – The outcome of the Greenwich Startwell Bid is will be announced shortly. YG – Due to the volume of papers, it would be helpful if the front page could set out the assurance, with the detail provided in a separate paper. SB – Committee chairs are asked to work with executive leads to take this forward.</td>
<td></td>
</tr>
</tbody>
</table>

Next meeting of the Board of Directors
Thursday 9 January 2020 at 10.30 am
Maple Room, Pinewood House
Question to Oxleas NHS Trust Board 7th November 2019 submitted by Francis Hook

Given that conditions at HMP Belmarsh have been well-reported in the media, especially the recent report by the Independent Monitoring Board, how has Oxleas NHS Trust Board responded to date and what further actions are planned with regard to healthcare and public health issues?


Background

The IMB report was published in October 2019 and made headline news eg:

Response

We deliver healthcare services in twelve prisons in London and Kent, including at HMP Belmarsh. Healthcare services are commissioned by NHS England against a standard core specification, with the ability for locally informed requirements to meet specific population needs. Broadly speaking, the obligation of NHS England is to ensure that provision is broadly equivalent to that available in the community. What this means is that people in prison should have direct access to primary (e.g. GP, dentistry, optometry, pharmacy) and community health services (e.g. community nursing, continence care, community mental health support) and the ability to access secondary care services for more complex physical and mental health needs. There is also a requirement to ensure national screening programmes are available.

Prisons are subject to statutory inspections by Her Majesty’s Inspectorate of Prisons (HMIP). HMIP are supported by the regulator of health and social care services, the Care Quality Commission (CQC) in respect of the provision of health services. The CQC have the same enforcement framework for health services in prisons as in the community.

HMIP and the CQC last inspected HMP Belmarsh in February 2018. A small number of recommendations were made regarding the delivery of healthcare. There was no enforcement action. All statutory inspections of our prison services are reviewed by the appropriate sub-committee of the Trust Board - this is our Performance and Quality Assurance Committee (PQAC). This is in addition to our directorate quality structure, which includes our seat on the Partnership Board at an individual prison level.

The Independent Monitoring Board (IMB) also inspects prisons and make recommendations based on their findings. Such recommendations are not within a statutory framework but they are valued by prisons. The most recent report relating to HMP Belmarsh made only one recommendation that related to healthcare, namely:

‘Will the Prison Service review the space available across the high security estate for prisoners with specific accommodation needs so that they are not kept in segregation or healthcare for extended periods?’

We do not have responsibility for the physical environment or the placement of people in prison.

Further comments on the IMB’s findings in respect of healthcare are made at page 18 of their report.

We are also voluntarily members of the Quality Network, which monitors the provision of mental health services within prisons through peer inspections. The findings from the Quality Network and IMB are reviewed within our directorate quality structure.
Question to Oxleas NHS Trust Board 7th November 2019 submitted by Francis Hook and Helen Mercer

How has Oxleas NHS Trust responded to the Royal College of Physicians guidelines for healthcare professionals working with victims of torture in detention in the following areas?


QS 1: Identification of victims of torture
Have healthcare professionals working at Belmarsh been trained to recognise indicators of possible past torture?

QS2: Ethical obligations
How does Oxleas NHS Trust provide support for healthcare professionals when working with victims of torture in detention to ensure their “professional, independent and ethical practices” and to “resist potential pressure from third parties”?

QS3: Consent and confidentiality
Has Oxleas NHS Trust ensured that healthcare professionals at Belmarsh conform to professional and ethical obligations to ensure that prisoners who may have been victims of torture maintain “their autonomy with regard to their own health and informed consent”

QS8 Training
Has Oxleas NHS Trust ensured that healthcare professionals working at Belmarsh “are appropriately trained and competent to care for victims of torture in detention”?

QS9: Assessment required for detention processes
How does Oxleas Trust monitor whether healthcare professionals at Belmarsh conform to professional and ethical obligations to ensure that any victims of torture in detention receive appropriate assessment of their vulnerability regarding their continued detention, segregation or fitness for interview and detailed questioning?

Background
We know that there is at least one person in Belmarsh prison who has been identified by the UN Rapporteur as a victim of psychological torture.

The Royal College of Physicians issued guidelines for healthcare professionals working with victims of torture, raising specific issues for healthcare service providers.


These state (rules 1 and 2)
“All prisoners shall be treated with the respect due to their inherent dignity and value as human beings. No prisoner shall be subjected to, and all prisoners shall be protected from, torture and other cruel, inhuman or degrading treatment or punishment, for which no circumstances whatsoever may be invoked as a justification. ....

The present rules shall be applied impartially. There shall be no discrimination on the grounds of race, colour, sex, language, religion, political or other opinion, national or social origin, property, birth or any other status. The religious beliefs and moral precepts of prisoners shall be respected.”
Response

Where we provide mental health and psychological therapy in prisons we operate a trauma informed model. This is because we know that very many of the men and women that we see will have suffered trauma and abuse during their lives. All our therapists are trained to recognise the signs and symptoms of trauma and there are a range of treatment options available. The two main barriers to delivering healthcare within a prison setting are the restrictive nature of the prison regime and a lack of engagement from the patient. These factors are particular relevant when it comes to the delivery of psychological therapy and accessing people in prison and we have strategies in place to address these barriers, including in-cell therapy and the use of emotional wellbeing mentors.

All staff are required to adhere to rules on patient confidentiality, with only exceptional circumstances where this can be breached where there are safeguarding or wider public interest concerns. Where this is agreed it must be documented that there has been a thorough assessment in respect of the risks.

All clinical staff receive at least six weekly supervision with a clinical supervisor where they are able to discuss individual cases and receive support and guidance. In addition, particularly for staff working with patients experiencing mental health problems, reflective practice sessions are in place to ensure staff feel supported and are able to talk about issues that they find distressing as well as ensuring that treatment plans in place are the most appropriate and will address the needs of the patient.

Oxleas NHS Trust Board meeting 7th November 2019 Question submitted by Helen Mercer

Given that Oxleas NHS Trust is the service provider commissioned by NHS England to provide healthcare services for HMP Belmarsh have all the Board of Directors been made aware of the following documents?

Has the Board addressed the implications of the conditions revealed in those reports for the provision of healthcare services at HMP Belmarsh?


Response

Please see response to question 1. Statutory inspection reports that directly relate to the delivery of healthcare within our prisons are received by an appropriate sub-committee of the Board. All other relevant reports and standards are considered at a service directorate level.
**Question submitted by: Juliana Johnston, 12 Franklin Place, London, SE13 7ES**

How has Oxleas NHS Trust, as the service providers for HMP Belmarsh, responded to the report by the UN Rapporteur on Torture on the continued detention of Julian Assange?

**Background**

Julian Assange, the founder of Wikileaks, is now on remand and imprisoned at HMP Belmarsh.

Julian Assange’s treatment by UK, Swedish and Ecuadorean authorities over the past nine years has been classified by independent United Nations experts as ‘arbitrary detention’, ‘the cumulative effects of which can only be described as psychological torture’. The UN Rapporteur on Torture, Nils Melzer, called specifically for Mr Assange to be examined by an independent specialist.

Mr Assange’s treatment in Belmarsh prison has exacerbated rather than alleviated these symptoms. At his most recent appearance in court (21st October 2019) Assange reportedly “seemed confused in giving his name and age” (Daily Telegraph)...he “struggled to say his own name, mumbling, pausing and stuttering as he gave his name and date of birth at the start of a case management hearing” (Daily Mail). Supporters and friends were shocked at the deterioration in his appearance since he was last seen publicly.

The Royal College of Physicians issued guidelines for healthcare professionals working with victims of torture, raising specific issues for healthcare commissioners.


“All prisoners shall be treated with the respect due to their inherent dignity and value as human beings. No prisoner shall be subjected to, and all prisoners shall be protected from, torture and other cruel, inhuman or degrading treatment or punishment, for which no circumstances whatsoever may be invoked as a justification. .... The present rules shall be applied impartially. There shall be no discrimination on the grounds of race, colour, sex, language, religion, political or other opinion, national or social origin, property, birth or any other status. The religious beliefs and moral precepts of prisoners shall be respected.”

**Response**

We cannot and should not provide any detail or information relating to an individual named patient.

All people entering prison receive a primary and secondary health screen that identifies urgent and ongoing health needs. This applies in all prisons, irrespective of category and status (sentenced and remand). For those with identified needs a plan of care and treatment is put in place. Emerging health needs are addressed as identified, normally by the person in prison themselves but occasionally through discipline staff who observe a change in behaviour or deterioration.
## Board of Directors
### 9 January 2020

<table>
<thead>
<tr>
<th>Item</th>
<th>3</th>
</tr>
</thead>
<tbody>
<tr>
<td>Enclosure</td>
<td>3</td>
</tr>
</tbody>
</table>

### Report Title
Matters arising

### Author
Sally Bryden, Trust Secretary

### Accountable Director
Andy Trotter, Chair

### Confidentiality/FOI status
Public

### Report Summary
The Board tracker details progress made on actions raised in previous Board meetings.

### Purpose
(To select purpose, click on relevant choice for drop down box)

<table>
<thead>
<tr>
<th>Information</th>
<th>To Note</th>
</tr>
</thead>
<tbody>
<tr>
<td>Approval</td>
<td>Decision</td>
</tr>
</tbody>
</table>

### Recommendation
The Board is asked to note.

### Link to strategic objectives
(Click on relevant choice for drop down box)

<table>
<thead>
<tr>
<th>Quality</th>
<th>Workforce</th>
<th>Sustainability</th>
<th>Partnerships</th>
</tr>
</thead>
</table>

### Link to Board Assurance Framework
There are links to risks relating to learning from serious incidents and in-patient services

### Implications
- Quality
- Financial
- Equality analysis
- Service user/carer/staff
<table>
<thead>
<tr>
<th>No</th>
<th>Minutes reference</th>
<th>Action raised (Board date)</th>
<th>Item</th>
<th>Action details</th>
<th>Action for</th>
<th>Bring forward to</th>
<th>Report under</th>
<th>Action closed</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>2019-09/#1</td>
<td>05/09/2019</td>
<td>PAS review</td>
<td>For the terms of reference of the review to be agreed and the outcome of the review to be reported to the Board.</td>
<td>Yemisi Gibbons</td>
<td>09/01/2020</td>
<td>PAS review</td>
<td>In progress</td>
<td>This is to be presented to the January Board of Directors’ meeting</td>
</tr>
<tr>
<td>2</td>
<td>2019-09/#2</td>
<td>05/09/2019</td>
<td>Operational Service report</td>
<td>For the board to receive a response on how the board are appraised of health and safety issues and the reporting route to the board</td>
<td>Sally Bryden</td>
<td>09/01/2020</td>
<td>TBA</td>
<td>In progress</td>
<td>This has been discussed at the November workforce committee and will be discussed further at Board strategy awayday</td>
</tr>
<tr>
<td>3</td>
<td>2019-11/#1</td>
<td>07/11/2019</td>
<td>Board questions from the public</td>
<td>KS to provide written response to individuals raising questions to the Board</td>
<td>Keith Soper</td>
<td>09/01/2020</td>
<td>Matters Arising</td>
<td>Closed</td>
<td>Response sent 21/11/2019</td>
</tr>
<tr>
<td>4</td>
<td>2019-11/#2</td>
<td>07/11/2019</td>
<td>Minutes of last meeting</td>
<td>Review of food hygiene visits and actions</td>
<td>Iain Dimond</td>
<td>09/01/2020</td>
<td>Matters Arising</td>
<td>In progress</td>
<td></td>
</tr>
<tr>
<td>5</td>
<td>2019-11/#3</td>
<td>07/11/2019</td>
<td>Minutes of last meeting</td>
<td>Outcome of discussion on anti-ligature works to be reported to the Board</td>
<td>Jane Wells</td>
<td>09/01/2020</td>
<td>Matters Arising</td>
<td>In progress</td>
<td></td>
</tr>
<tr>
<td>6</td>
<td>2019-11/#4</td>
<td>07/11/2019</td>
<td>Mortality Surveillance Committee</td>
<td>Update on LEDER learning to be brought to January Board meeting</td>
<td>Jane Wells</td>
<td>09/01/2020</td>
<td>Service presentation</td>
<td>In progress</td>
<td>Presentation to be made to January meeting</td>
</tr>
<tr>
<td>Report Title</td>
<td>Board Assurance Framework</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>----------------</td>
<td>---------------------------</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Author</td>
<td>Susan Owen, Risk and Governance Manager</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Accountable Director</td>
<td>Matthew Trainer, Chief Executive</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Confidentiality/FOI status</td>
<td>N/A</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Report Summary**

**New Board Assurance Framework risks**

**1844:** CMHT demand is higher than capacity, which impacts on the organisation's ability to meet patient need in a timely and effective way. In some areas, recruitment and retention remains an area of concern. This creates a risk to patient experience and delivering the service.

This is a new risk identified by the Executive Team in light of concerns about demand and capacity in CMHTs. The CMHT Forum has developed a workplan of key areas to address during 2020, and a high level response to the risk will also be discussed by the Executive Team. The risk has been rated consequence = 4, likelihood = 3, risk rating = HIGH (12).

**Risks de-escalated from the Board Assurance Framework**

**1763:** If actions agreed as a result of serious incident inquiries are not completed in a timely manner, there is a risk that the trust may not implement learning and take action to improve practice and quality.

The Audit and Risk Assurance Committee agreed that this risk can be de-escalated from the BAF. Oversight of this risk will continue to be monitored by the Patient Safety Team and the Serious Incident Group.

**Other exceptions to note**

**1695:** Whilst practical controls are in place to ensure the safety of patients and staff, this is not in the context of the overall site management plan, and the trust has not received statutory compliance information from our landlords, so we cannot be assured that fire safety checks are in place.

This risk has been re-worded to reflect that the risk concerns relate to the receipt of statutory compliance information. NHS Property Services have instructed an external expert to develop a site wide fire safety plan, and the associated compliance documentation. The trust has been advised by NHS Property Services that they are committed to providing this by the end of January 2020.

**1776:** There have been some instances where a patient detained under s136 has been assessed as requiring admission, and no bed is available, either within our own bed base, or in the private sector; patients are therefore kept in the Health Based Place of Safety (HBPoS) beyond 24 hours. There is a risk that this will impact on patient care, privacy and dignity; that the trust will be deprived of a HBPoS; and a risk of legal action for unlawful detention.

Data on breaches of the 24 hour rule is collated every two months for the Mental Health Legislation Oversight Group, so updated data will be included in the March 2020 board report. The KPMG audit of s136 compliance is due to presented to the Audit and Risk Assurance Committee on 21 January 2020.
### Workforce Committee risks

The three Workforce Committee risks have been reviewed by the Director for Strategy and People and Associated Director for Workforce. An updated version will be presented to the Workforce Committee for approval on 15 January 2020, and then to the Audit and Risk Assurance Committee on 21 January 2020 as part of the programme of rotational risks reporting.

<table>
<thead>
<tr>
<th>Purpose (To select purpose, click on relevant choice for drop down box)</th>
<th>Information</th>
<th>To Note</th>
<th>√</th>
</tr>
</thead>
<tbody>
<tr>
<td>Approval</td>
<td></td>
<td>Decision</td>
<td></td>
</tr>
</tbody>
</table>

| Recommendation | For the Board of Directors to note |

<table>
<thead>
<tr>
<th>Link to strategic objectives (click on relevant choice for drop down box)</th>
<th>Quality</th>
<th>Workforce</th>
<th>Sustainability</th>
<th>Partnerships</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>√</td>
<td>√</td>
<td>√</td>
<td>√</td>
</tr>
</tbody>
</table>

| Link to Board Assurance Framework | N/A |

### Implications

Briefly outline implications of the recommendations in this report

**Quality**
The BAF includes risks relating to quality

**Financial**
The BAF includes risks relating to finances

**Equality analysis**

**Service user/carer/staff**
The BAF includes risks relating to workforce and user/carer/staff safety

<table>
<thead>
<tr>
<th>New BAF risks</th>
<th>Current (C x L)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>1844</strong>: CMHT demand is higher than capacity, which impacts on the organisation’s ability to meet patient need in a timely and effective way. In some areas, recruitment and retention remains an area of concern. This creates a risk to patient experience and delivering the service</td>
<td>HIGH (12) (4 x 3)</td>
</tr>
<tr>
<td>Item 12</td>
<td>Operational Committee</td>
</tr>
<tr>
<td>----------</td>
<td>------------------------</td>
</tr>
<tr>
<td>1. CCG contingency reserves</td>
<td>• Ensure that each patient admitted to an acute ward has a purposeful admission and that discharge is not delayed</td>
</tr>
<tr>
<td>2. Safety</td>
<td>• Undertake a review of existing procedures for safeguarding identified residents</td>
</tr>
<tr>
<td>3. Bed demand and capacity</td>
<td>• Ensure that care offered in the community is not delayed</td>
</tr>
<tr>
<td>4. CCG contingency reserves</td>
<td>• Ensure that each patient admitted to an acute ward has a purposeful admission and that discharge is not delayed</td>
</tr>
<tr>
<td>5. CCG contingency reserves</td>
<td>• Ensure that each patient admitted to an acute ward has a purposeful admission and that discharge is not delayed</td>
</tr>
<tr>
<td>6. Safety</td>
<td>• Undertake a review of existing procedures for safeguarding identified residents</td>
</tr>
<tr>
<td>7. Bed demand and capacity</td>
<td>• Ensure that care offered in the community is not delayed</td>
</tr>
<tr>
<td>8. CCG contingency reserves</td>
<td>• Ensure that each patient admitted to an acute ward has a purposeful admission and that discharge is not delayed</td>
</tr>
<tr>
<td>9. Safety</td>
<td>• Undertake a review of existing procedures for safeguarding identified residents</td>
</tr>
<tr>
<td>10. Bed demand and capacity</td>
<td>• Ensure that care offered in the community is not delayed</td>
</tr>
<tr>
<td>11. CCG contingency reserves</td>
<td>• Ensure that each patient admitted to an acute ward has a purposeful admission and that discharge is not delayed</td>
</tr>
<tr>
<td>12. Safety</td>
<td>• Undertake a review of existing procedures for safeguarding identified residents</td>
</tr>
<tr>
<td>13. Bed demand and capacity</td>
<td>• Ensure that care offered in the community is not delayed</td>
</tr>
<tr>
<td>14. CCG contingency reserves</td>
<td>• Ensure that each patient admitted to an acute ward has a purposeful admission and that discharge is not delayed</td>
</tr>
<tr>
<td>Date</td>
<td>Risk level</td>
</tr>
<tr>
<td>------------</td>
<td>------------</td>
</tr>
<tr>
<td>26/08/2018</td>
<td>High</td>
</tr>
<tr>
<td>31/03/2021</td>
<td>Low</td>
</tr>
<tr>
<td>18/09/2019</td>
<td>Likely (3)</td>
</tr>
<tr>
<td>18/09/2019</td>
<td>Moderate (3)</td>
</tr>
<tr>
<td>18/09/2019</td>
<td>High</td>
</tr>
<tr>
<td><strong>Report Title</strong></td>
<td>Chief Executive Report</td>
</tr>
<tr>
<td>------------------</td>
<td>------------------------</td>
</tr>
<tr>
<td><strong>Author</strong></td>
<td>Matthew Trainer, CEO</td>
</tr>
<tr>
<td><strong>Accountable Director</strong></td>
<td>Matthew Trainer, CEO</td>
</tr>
<tr>
<td><strong>Confidentiality/FOI status</strong></td>
<td>Public</td>
</tr>
</tbody>
</table>

**Report Summary**
The purpose of this report is to provide the Trust Board with the Chief Executive Officer’s update on significant developments and key issues over the past two months. The Board is asked to receive and note the report.

The key issues in the report are:
- Queen’s Speech – health and social care announcements
- Our Healthier South East London Partnership update
- South London Partnership developments
- Our Next Step strategy development programme

**Purpose (To select purpose, click on relevant choice for drop down box)**
- Information
- Approval

**Recommendation**
For the Board of Directors to note the report

**Link to strategic objectives click on relevant choice for drop down box**
- Quality
- Workforce
- Sustainability
- Partnerships

**Link to Board Assurance Framework**
This report links to several risks on the Board assurance framework including 1565.
1. National developments

Health and Social Care announcements in The Queen’s Speech, December 2019

The Queen’s Speech introduced three bills directly related to health and social care (the NHS Funding Bill, the Health Service Safety Investigations Bill and Medicines and Medical Devices Bill). It is also expected that legislation to implement the NHS long term plan will be drafted.

A white paper on reforming the Mental Health Act is also expected in the New Year.

European Union (Withdrawal Agreement) Bill

This was approved by Parliament on 20 December and is expected to pass before 31 January 2020. We will be working with the wider NHS community to prepare for the changes this will bring.

2. Local developments

Our Healthier South East London Partnership Update

Following consultation with provider boards and clinical commissioning group governing bodies, the Our Healthier South East London Board reviewed the partnership response to the NHS Long Term Plan on 13 November. A summary of the plans aimed for a wider audience is to be published shortly.

From April 2020, the six Clinical Commissioning Groups (CCGs) in south east London (Bexley, Bromley, Greenwich, Lambeth, Lewisham and Southwark) will form a single South East London CCG. The CCGs have received confirmation that NHS England has approved the merger application to become South East London CCG on 1 April 2020. All six CCG Governing Bodies support this move and GP memberships have voted in favour of the proposal.

3. Partnership highlights

South London Partnership

NHS England/Improvement have confirmed that we are still on track to become a Lead Provider for the South London Adult Secure Provider Collaborative (see appendix 1). The financial aspects of the proposal are still being developed and will be shared with the Board for approval.

A review of the governance arrangements for the South London Partnership is underway with consideration of each trust setting up a SLP sub-committee of the Board which would then meet in common.
South London and Maudsley NHS Foundation have announced two new board appointments. Sir Norman Lamb has been appointed as Chair and Helen Edwards CB, CBE as non-executive director. They will take up their roles in March 2020.

4. Oxleas developments

Our Next Step programme

The first phase of the Our Next Step strategy development programme finished in December. The aim of this first phase was to give individuals the opportunity to share their personal views of what Oxleas’ priorities should be. During this phase we heard from more than 750 people through:

- On-line survey for staff and members
- Feedback forms across the whole organisation
- 5 Closer to Home events in Bexley, Bromley, Greenwich and Kent
- Our Next Step focus groups in inpatient units and team meetings.
- Events for senior staff group, Board awayday and Council of Governors plus discussions with professional network groups.

Some of the themes that are arising from this initial feedback include:

- Better access to services and shorter waiting times
- More staff development and training
- More social opportunities for staff
- Increasing use of technology to improve care and patient/staff experience
- Improved systems to support effective working

The full range of feedback will be analysed and used for the next stage of the engagement process. This will take place in the New Year and will involve asking teams to discuss the suggestions and prioritise what they believe is most important. We will also be undertaking a wide range of engagement activities with service user groups and key stakeholders.

Alongside this, we are setting up staff assemblies and encouraging colleagues to get involved. We will be meeting with groups within directorates in the New Year and aim to set up a conference in February for people interested in running the assemblies in their directorates. Therefore, during the first part of 2020 we will be trying out the staff assembly approach with colleagues with the aim of developing a more permanent framework for taking them forward. To support the work of the staff assemblies to improve working lives, we will be making £10,000 of charitable funds available to each assembly to support wellbeing activities.

As part of the engagement process, we have been using a wide variety of communication methods including film, team briefings and e-bulletins. We are also trialling webinars as a more immediate and direct form of interaction.
Start Well Greenwich

On 13 November 2019, the Royal Borough of Greenwich Cabinet meeting approved the recommendations of a report ‘Start Well Greenwich - Children and Young People’s Health and Wellbeing Services 2020’. These recommendations impact on the future of Greenwich Health Visiting services.

Health visiting services in Bromley have also been put out to tender.

Technology developments

We are exploring new ways to increase our use of technology to improve care and patient and staff experience.

Trust leadership developments

Our Finance Director Jazz Thind has been seconded to Imperial College Healthcare NHS Trust as Interim Chief Financial Officer for six months. While she is away, Azara Mukhtar will join us as Interim Finance Director.
Dear Matthew and Jeremy

Provider Collaboratives in Specialised Mental Health, Learning Disability and Autism Services: Next Steps

Thank you for submitting your updated business case as Lead Provider for the South London Adult Secure Provider Collaborative and for joining panel discussions.

I am pleased to confirm that you will continue to be on track to become a Lead Provider from April 2020 and are considered a Fast Track submission.

As discussed at our panel meeting on 12 December, there are a number of financial issues that need to be resolved by the end of January, to enable you to go live on the 1st April 2020. We will continue to work with you on addressing these. These include:

- Whether surpluses can be carried forward?
- Confirmation of baselines, including Transforming Care
- Assurance on the financial risk
- Clarity on business rules and how money will flow
- Agreement on the 2 EPoC high costs cases

Whilst we did not discuss liabilities and SOPs for foreign nationals, we are in discussion with the national team and will get clarity on this by the end of March.

The panel also had feedback in some areas, which you may find helpful in further strengthening the operating framework of your Provider Collaborative. This is detailed below:

- Criteria 2 Board Assurance (clinical and operational Leadership): Given the complexity of relationships within the Provider Collaborative and the role of the Lead Provider, you may want to further review lines of accountability, due diligence of Boards/Committees, and how conflicts of interest will be managed. It may be helpful to use scenarios to further illustrate this.
• **Criteria 3 Business Case: meeting needs of patients with LD/ASD:**

  **Governance:** Given the needs of this client group and national priorities around learning disabilities and autism, we would like collaboratives to appoint an SRO to further strengthen governance arrangements and also identify clinical champions at an operational level.

  **Ongoing support:** We are planning a quarterly regional meeting to align activities and share information. There are also national meetings attended by the current NHSE team that provider collaboratives will be invited to join to update on the London position.

  **Accessing knowledge and learning:** We are aware that South London Partnership has a comprehensive knowledge of the cohort of people with learning disabilities and/or autism in secure services. Our team is currently in the process of uploading CTR reports and other key documents to the SMH database.

  **Personalised Care:** Although this was not discussed at our meeting, you should be aware of the right for people with a learning disability and/or autism to have a Personalised Health Budget.

• **Criteria 5 Service user, carer and family/ friends' engagement and involvement:** We would recommend that you consider an Expert by Experience co-chair of your Collaborative Board and further embed Experts by Experience in your governance framework.

• **Criteria 6 Provider Partnership leadership:** As discussed, carrying out a population needs assessment to understand current and future needs should be a key priority, alongside demand and capacity modelling. As you continue conversations with the independent sector, it will be important to confirm commissioning intentions (for 20/21) over the transition period.

• **Criteria 8 Quality Infrastructure:** It will be useful for the Provider Collaborative to have a flowchart showing escalation thresholds e.g. when an issue is escalated to lead provider, what is managed by individual providers, the rationale for escalation and the process that is to be followed. Also the role of Case Managers within the process.

As you are aware, the TUPE joint staff consultation is now underway and we will continue to work with you on this, confirming arrangements by the end of January in preparation of go live.

We will work together with you on planning on a London basis. Over the course of January we will have individual conversations with you about what will be helpful in terms of support, during transition and post go live. You will also shortly receive the December programme update from the national team about their planned support offer.
Our next steps are to present a recommendation paper to the London Regional Executive Team in February, with final approval at the March meeting.

We look forward to working with you over the next few months to ensure that you are ready to go Live on the 1st April 2020.

Yours sincerely

Joanne Murfitt  
Regional Director of Specialised Commissioning and Health in the Justice

cc:  
Vimbai Egaru  
Keith Soper  
Iain Dimond  
Mary Harty  
John Reeves
### Report Title
Integrated Board Report (IBR)

### Author
Karen Kennedy, Business Intelligence and Performance

### Accountable Director
Iain Dimond, Chief Operating Officer

### Confidentiality/FOI status

<table>
<thead>
<tr>
<th>Report Summary</th>
</tr>
</thead>
<tbody>
<tr>
<td>Over the last few months we have introduced the use of Statistical Process Control (SPC) charts to present data in a more informative way. For our Integrated board report and NHSI dashboard we will no longer use a RAG rating system to measure performance. Instead we will look at both variation in performance over the last 6 months to identify any special cause of concern and assurance to see if we are consistently passing or failing to reach the target. This will help us identify which metrics we need to focus on for improvement. The variance and assurance columns can be seen on right hand side of the attached dashboard. Exception reports will be produced if the metric has failed to reach the target for 4 out of the last 6 months and is still failing 🕹️ icon will show in the Assurance column on the dashboard) Exception reports will not be required for metrics that are showing special cause, if the target is not yet failing 🕹️, 🕹️ (the special cause symbols, - will show in the Variation column on the dashboard). It is expected that services will be following up locally to understand the reasons for the variation and reacting appropriately. This month, at a Trust level there are 8 areas within the IBR which have consistently failed to meet target over the last 6 months and exception reports are provided. In addition, the NHSI MH FFT metric is also failing to meet target and is showing special cause. An exception report is also provided.</td>
</tr>
<tr>
<td>Purpose</td>
</tr>
<tr>
<td>---------</td>
</tr>
<tr>
<td>Approval</td>
</tr>
</tbody>
</table>

**Recommendation**

Clear outline of what the committee is being asked to agree/discuss/note. Items for information will not allocated time for discussion within meeting.

<table>
<thead>
<tr>
<th>Link to strategic objectives (click on relevant choice for drop down box)</th>
<th>Quality ✓</th>
<th>Workforce</th>
<th>Sustainability ✓</th>
<th>Partnerships</th>
</tr>
</thead>
</table>

**Link to Board Assurance Framework**

<table>
<thead>
<tr>
<th>Implications</th>
<th>Briefly outline implications of the recommendations in this report</th>
</tr>
</thead>
<tbody>
<tr>
<td>Quality</td>
<td></td>
</tr>
<tr>
<td>Financial</td>
<td></td>
</tr>
<tr>
<td>Equality analysis</td>
<td></td>
</tr>
<tr>
<td>Service</td>
<td></td>
</tr>
<tr>
<td>user/carer/staff</td>
<td></td>
</tr>
</tbody>
</table>
### Integrated Performance Report (IPR) - November 2019

<table>
<thead>
<tr>
<th>S.No</th>
<th>Committee</th>
<th>Reported</th>
<th>Origin</th>
<th>Metric Code</th>
<th>View from our regulators</th>
<th>Target Nov-19</th>
<th>Comments - November 2019</th>
<th>Variance</th>
<th>Assurance</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Monthly</td>
<td>NSI</td>
<td>10766</td>
<td>NPS Improvement - Segment</td>
<td></td>
<td>1</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2</td>
<td>N/A</td>
<td>CQC</td>
<td>10534</td>
<td>CQC Rating</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Green</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>S.No</th>
<th>Committee</th>
<th>Reported</th>
<th>Origin</th>
<th>Metric Code</th>
<th>View from our regulators</th>
<th>Target Nov-19</th>
<th>Comments - November 2019</th>
<th>Variance</th>
<th>Assurance</th>
</tr>
</thead>
<tbody>
<tr>
<td>3</td>
<td>Quality</td>
<td>Monthly</td>
<td>10331</td>
<td>4 Must Dos - Worked with dignity and respect</td>
<td>&gt;90%</td>
<td>98.2%</td>
<td>RAG: Green &gt;90, Amber &gt;84-90, Red &lt;85.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>4</td>
<td>Quality</td>
<td>Monthly</td>
<td>10381</td>
<td>4 Must Dos - Worked with dignity and respect</td>
<td>&gt;90%</td>
<td>95.7%</td>
<td>RAG: Green &gt;90, Amber &gt;84-90, Red &lt;85.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>5</td>
<td>Quality</td>
<td>Monthly</td>
<td>10382</td>
<td>4 Must Dos - Worked with dignity and respect</td>
<td>&gt;90%</td>
<td>97.1%</td>
<td>RAG: Green &gt;90, Amber &gt;84-90, Red &lt;85.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>6</td>
<td>Quality</td>
<td>Monthly</td>
<td>10340</td>
<td>Friends and Family Test (FFT) - % not recommended</td>
<td>&lt;10%</td>
<td>2.8%</td>
<td>RAG: Green &gt;90, Amber &gt;84-90, Red &lt;85.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>7</td>
<td>Quality</td>
<td>Monthly</td>
<td>10339</td>
<td>FFT - % recommended</td>
<td>&gt;90%</td>
<td>89.6%</td>
<td>RAG: Green &gt;90, Amber &gt;84-90, Red &lt;85.</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Committee</th>
<th>Reported</th>
<th>Origin</th>
<th>Metric Code</th>
<th>View from our regulators</th>
<th>Target Nov-19</th>
<th>Comments - November 2019</th>
<th>Variance</th>
<th>Assurance</th>
</tr>
</thead>
<tbody>
<tr>
<td>8</td>
<td>Quality</td>
<td>Monthly</td>
<td>10768</td>
<td>Delayed Transfers of Care</td>
<td>&lt;7.5%</td>
<td>4.6%</td>
<td>RAG: Green &lt;7.50%, Red.</td>
<td></td>
</tr>
<tr>
<td>9</td>
<td>Quality</td>
<td>Monthly</td>
<td>11138</td>
<td>6 Week Wait for Audiology Diagnostic Assessment (DIM3 Monthly)</td>
<td>&gt;99%</td>
<td>100.0%</td>
<td>RAG: Green &gt;99%, Amber &lt;99%, Red.</td>
<td></td>
</tr>
<tr>
<td>10</td>
<td>Quality</td>
<td>Monthly</td>
<td>11403</td>
<td>Performance against 30 working day target for Responding to complaints</td>
<td>&gt;80%</td>
<td>75.0%</td>
<td>RAG: Green &gt;80%, Amber &gt;60-80, Red &lt;60.</td>
<td></td>
</tr>
<tr>
<td>11</td>
<td>Quality</td>
<td>Monthly</td>
<td>11404</td>
<td>Performance against outstanding actions identified from Complaints</td>
<td>&gt;90%</td>
<td>64.7%</td>
<td>Please see exception report</td>
<td></td>
</tr>
<tr>
<td>12</td>
<td>Quality</td>
<td>Monthly</td>
<td>10335</td>
<td>4 Must Dos - Enough information about care and treatment</td>
<td>&gt;90%</td>
<td>96.1%</td>
<td>RAG: Green &gt;95, Amber 85-95, Red &lt;85</td>
<td></td>
</tr>
<tr>
<td>13</td>
<td>Quality</td>
<td>Monthly</td>
<td>10336</td>
<td>4 Must Dos - Involved in decisions about care and treatment</td>
<td>&gt;90%</td>
<td>95.1%</td>
<td>RAG: Green &gt;95, Amber 85-95, Red &lt;85</td>
<td></td>
</tr>
<tr>
<td>14</td>
<td>Quality</td>
<td>Monthly</td>
<td>11268</td>
<td>Referral to Treatment - Allied Health Professionals (New - April 2018)</td>
<td>&gt;95%</td>
<td>92.8%</td>
<td>RAG: Green &gt;95, Amber 85-95, Red &lt;85</td>
<td></td>
</tr>
<tr>
<td>15</td>
<td>Quality</td>
<td>Monthly</td>
<td>10024</td>
<td>Referral to treatment for Psychological Therapies (PT)</td>
<td>&gt;95%</td>
<td>88.1%</td>
<td>RAG: Green &gt;95, Amber 85-95, Red &lt;85</td>
<td></td>
</tr>
<tr>
<td>16</td>
<td>Quality</td>
<td>Monthly</td>
<td>10248</td>
<td>Referral to treatment for incomplete care pathways</td>
<td>&gt;92%</td>
<td>97.7%</td>
<td>RAG: Green &gt;90, Amber 84-95, Red &lt;85</td>
<td></td>
</tr>
<tr>
<td>17</td>
<td>Quality</td>
<td>Monthly</td>
<td>11397</td>
<td>Percentage of patients seen within 12 months for an initial Autism Spectrum Disorder (ASD) Appointment</td>
<td>TBC</td>
<td>53.0%</td>
<td>New metric awaiting sign-off</td>
<td></td>
</tr>
<tr>
<td>18</td>
<td>Quality</td>
<td>Monthly</td>
<td>11503</td>
<td>Percentage of patients seen within 12 weeks for an initial CAMHS Appointment</td>
<td>TBC</td>
<td>77.2%</td>
<td></td>
<td></td>
</tr>
<tr>
<td>19</td>
<td>Quality</td>
<td>Monthly</td>
<td>11505</td>
<td>Percentage of patients seen within 18 weeks for a second CAMHS Appointment</td>
<td>TBC</td>
<td>77.2%</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Committee</th>
<th>Reported</th>
<th>Origin</th>
<th>Metric Code</th>
<th>View from our regulators</th>
<th>Target Nov-19</th>
<th>Comments - November 2019</th>
<th>Variance</th>
<th>Assurance</th>
</tr>
</thead>
<tbody>
<tr>
<td>20</td>
<td>Quality</td>
<td>Monthly</td>
<td>10304</td>
<td>CPA 7 Day follow up (Discharge from inpatient setting)</td>
<td>&gt;95%</td>
<td>95.2%</td>
<td>RAG: Green &gt;95%, Amber 60-95, Red &lt;60.</td>
<td></td>
</tr>
<tr>
<td>21</td>
<td>Quality</td>
<td>Monthly</td>
<td>11519</td>
<td>COUIN 72 Hour Post Discharge Follow Up</td>
<td>80%</td>
<td>93.0%</td>
<td>RAG: Green &gt;80%, Amber &gt;50%, Red &gt;50%. New metric: September 2019. This metric includes follow up for all discharged patients from MH wards. Work continues to embed the new processes.</td>
<td></td>
</tr>
<tr>
<td>22</td>
<td>Quality</td>
<td>Monthly</td>
<td>11520</td>
<td>72 Hour Post Discharge Follow Up (Self Harm)</td>
<td>100%</td>
<td>100.0%</td>
<td>RAG: Green &gt;100, Red &lt;100. New metric: September 2019. This metric includes follow up for all discharged patients from MH wards. Work continues to embed the new processes.</td>
<td></td>
</tr>
<tr>
<td>23</td>
<td>Quality</td>
<td>Monthly</td>
<td>10542</td>
<td>Adult Acute Bed occupancy (excluding leave)</td>
<td>&lt;100%</td>
<td>96.2%</td>
<td></td>
<td></td>
</tr>
<tr>
<td>24</td>
<td>Quality</td>
<td>Monthly</td>
<td>10463</td>
<td>OPCMH Acute Bed occupancy (excluding leave)</td>
<td>&lt;100%</td>
<td>92.4%</td>
<td></td>
<td></td>
</tr>
<tr>
<td>25</td>
<td>Quality</td>
<td>Monthly</td>
<td>10343</td>
<td>Adult Community Intermediate Care Bed Occupancy</td>
<td>85-95%</td>
<td>94.0%</td>
<td></td>
<td></td>
</tr>
<tr>
<td>26</td>
<td>Quality</td>
<td>Monthly</td>
<td>10869</td>
<td>Crisis Home Treatment Team Gatekeeping - Oct 2017 onwards</td>
<td>&gt;95%</td>
<td>97.1%</td>
<td>RAG: Green &gt;90, Amber &gt;70, Red &gt;70.</td>
<td></td>
</tr>
<tr>
<td>27</td>
<td>Quality</td>
<td>Monthly</td>
<td>10446</td>
<td>Prisons (Number of Secondary Screens Completed in the First 72 Hours against Number of Receptions)</td>
<td>&gt;95%</td>
<td>87.7%</td>
<td></td>
<td></td>
</tr>
<tr>
<td>28</td>
<td>Quality</td>
<td>Monthly</td>
<td>10355</td>
<td>No of incidents (1-3)</td>
<td>N/A</td>
<td>905</td>
<td></td>
<td></td>
</tr>
<tr>
<td>29</td>
<td>Quality</td>
<td>Monthly</td>
<td>10356</td>
<td>No of Serious incidents (4-5) (excluding pressure ulcers)</td>
<td>N/A</td>
<td>4</td>
<td></td>
<td></td>
</tr>
<tr>
<td>30</td>
<td>Quality</td>
<td>Monthly</td>
<td>10447</td>
<td>Incidents of category 3 and 4 Pressure Ulcers</td>
<td>N/A</td>
<td>22</td>
<td></td>
<td></td>
</tr>
<tr>
<td>31</td>
<td>Quality</td>
<td>Monthly</td>
<td>10448</td>
<td>Medication errors</td>
<td>N/A</td>
<td>31</td>
<td></td>
<td></td>
</tr>
<tr>
<td>32</td>
<td>Workforce &amp; Development</td>
<td>Monthly</td>
<td>10334</td>
<td>Vacancy Rate</td>
<td>&lt;14%</td>
<td>8.0%</td>
<td>RAG: &lt;=14 Green, 14-17 Amber, &gt;17 Red.</td>
<td></td>
</tr>
</tbody>
</table>
## Workforce & Development

<table>
<thead>
<tr>
<th>S.No</th>
<th>Committee</th>
<th>Reported</th>
<th>Origin Code</th>
<th>Metric Code</th>
<th>Target</th>
<th>Nov-19</th>
<th>Comments - November 2019</th>
<th>Variance</th>
<th>Assurance</th>
</tr>
</thead>
<tbody>
<tr>
<td>31</td>
<td>Workforce &amp; Development</td>
<td>Monthly</td>
<td>Trust</td>
<td>10045</td>
<td>Vacancies - Exceptions Pensions</td>
<td>&lt;14%</td>
<td>19.4%</td>
<td>RAG: =&gt;14 Green; 14-17 Amber; &gt;17 Red.</td>
<td></td>
</tr>
</tbody>
</table>

### Rules
- **Performance** is reviewed over the previous 6 months. For **Variance** - Special cause is determined if trend overall is improving or deteriorating. If there is no obvious trend then common cause is applied. For **Assurance** the metric must have failed to reach target for at least 4 of the last 6 months and is still failing.
Target: 80%. Due to low number of denominators impact of any breaches on overall percentages is felt acutely. However, considering that this is one of our newer metrics, it is anticipated that reporting this data monthly will encourage improvements in response times.

Actions to Improve

**Bromley:** Recently there have been a number of complaints that have had an extension to the response date agreed by the complainant, however, these are still recorded as breaches due to the original date being missed. Currently a reminder is sent to the allocated handler but we will look into implementing additional reminders to see if this improves performance. If it doesn’t then we will look to see if a QI project could be commenced to improve performance.

**Greenwich:** Response times to complaints is now the subject for a Qi project. Drivers for change have been identified and are being implemented via a PDSA cycle. Regular meetings take place to review the impact of the change and will continue to address the issue. It is anticipated that improvement will be demonstrated early 2020. 127 staff identified who require training to be IOs. 25/175 trained in November and a further 25 to be trained in March. All those trained are then added to the top of the taxi rank to undertake complaint investigations at the earliest opportunity.
SPC Charts

Target: 80% - What do the charts tell us?
Due to low number of denominators impact of any breaches on overall percentages is felt acutely. However, considering that this is one of our newer metrics, it is anticipated that reporting this data monthly will encourage improvements in response times.

Actions to Improve

**Bexley:**
- September: 5 complaints received
  - 2 were responded to within their original timescales
  - 2 breached their original timescales
  - 1 breached its agreed extension
- October: 6 complaints received
  - 3 were responded within their original timescales
  - 2 were responded within their extended timescales
  - One is currently still within its original timescale

In regard to turn around on complaints we were late returning several complaints due to senior capacity to review final drafts. One MP investigation was delayed with the IO and then whilst final response was approved. The taxi rank and buddy system are now in place.

**Bromley:** As with the 30 day target, we will look into implementing an additional reminder to the process to remind complaint handlers/those responsible for actions that the deadline for completing actions is approaching to see if this improves performance. If it doesn’t then we will look to see if a QI project could be commenced to improve performance.

**Greenwich:** Actions are being monitored via the Directorate PEG meeting.
**Target:** <14%

**What do the charts tell us?**
Data shows a steady improvement in vacancy rates for the prison service for the last year with service meeting the trust target of 14% in June. However between August and end of September the vacancy rate increased to 26%. This is due to us taking on HMP Wandsworth in September which has significantly higher vacancy rates than our other services.

**Actions to Improve:**
We have had a focussed recruitment event RCNi for prison services, and are doing various projects to promote awareness of working in prison for RGNs, we expect some improvement on the position by January 2020. In the longer term we are looking at apprenticeships, academic offerings and rotations to attract/develop a specialist prison workforce.

"Prisons have taken a hit with the TUPE and go live of Wandsworth which saw us inherit, from September, a larger than normal vacancy rate into the Trust. As such there was a full recruitment drive in November with interviews through last week and this week for bands 7, 6, 5 and 3. Management are rather optimistic that a reasonable dent in the 30% vacancy figure by the end of quarter 1 all of which though will need Prison clearance and Oxleas recruitment clearance (something that has also resulted in delays to start dates over the past few months).

For Greenwich cluster a key area of vacancies is Band 5 Nursing. In terms of the plan to remedy the position, there were recruitment fairs. One took place around September/October time but did not generate any recruits."
Metric 10323 - Ensure patients detained under the MHA are provided with info as stated – recorded on RIO (S132)

SPC Charts

Analysis

Target: 100%

What do the charts tell us?
Performance has failed to reach target for the last year but has deteriorated significantly in the last 3 months. This is apparent in Bromley and Greenwich whereas Bexley performance appears more random although in September they dropped outside of the lower control limit.

Actions to improve:

Bexley: The number of new detentions each month in Bexley wards is low, meaning one breach can have a large impact on % performance. Review of breaches shows that attempts were made by nursing staff to explain rights to the patients. These have been documented in progress notes but not in the appropriate section on RiO. Patients concerned displayed a variety of challenging presentations, described as disorientated and very aggressive. One breach was due to a new member of staff not following the correct process - this has been addressed in supervision.

Bromley: Having investigated the performance for Bromley, performance has dipped and as with the 6 month CPA reviews, we are reviewing the method of reporting/monitoring actions against previous breaches to ensure learning. Teams have also been reminded about the importance of explaining and recording that rights have been explained.

Greenwich: Compliance remains within tolerated levels, however, downward trend from 100% in July to 90.5% in October. This is being monitored in performance meetings.
Metric 10325 - Ensure consent to treatment is obtained from clients assessed and detained under the MHA (S58)

Target: 100%

What do the charts tell us?

Performance has been quite random over the last 6 months with the metric failing to achieve target on 5 occasions. This pattern is similar for Bromley and Greenwich. Bexley has had the most consistent performance with meeting target 4 months out of the last 6 but has failed to meet target for the last 2 months.

Actions to improve:

Bexley: The one breach in September was on Scadbury ward and not within a Bexley area of management. Francis will discuss with Adrian Dorney to ensure this has been reviewed.

Bromley: Following discussions this week with regards to our performance reporting at our monthly PQAM meetings, we are reviewing the method/style of our reporting and are looking to see what additional information should be reported, this area will be considered for inclusion in the new report.

Greenwich: Compliance remains at 100%.
Metric 10322 – MH CPA Service user reviews after 6 months

SPC Charts

Analysis

Target: >95%

What do the charts tell us?
Data shows a steady decline in performance over the year, despite a brief rally in September and October, the target was missed last month. Bexley and Greenwich show more variation in performance but Bromley is showing the greatest deterioration in performance.

Actions to Improve:

**Bexley:** Although there had been a downward trend earlier in the year, we have seen steady improvement reaching 96.1% in October and 94.8% in Nov. We continue to contact teams on a monthly basis with outstanding CPA reviews, and have noted that often these are due to data entry issues in RiO.

**Bromley:** Bromley - Breaches of 6 month CPA reviews are highlighted at our monthly PQAM meetings. We have discussed this week a new approach to reporting these to ensure that previous breaches have been addressed.

**Greenwich:** Compliance remains within tolerated levels, however, downward trend from 92.5% in September to 90.1% in November is being monitored in performance meetings.
Target: <4% - What do the charts tell us?

The last 4 months has seen an increase in sickness absence to over the target of 4%. Only Bromley has consistently met the target for the last 4 months.

Actions to Improve:

The increase in sickness absence rate reflects the trend seen in previous years during the winter months. There is a significant increase in absences related to cough/cold/flu and gastrointestinal problems. The highest rates of absence were recorded in Bexley Care (5.57%), C&YP (5.03%), Greenwich (5.14%) and Prisons (5.34%). Targeted action is being taken to address absence across the teams, with a renewed focus on short and medium term absence management. A reduction in the absence rate for the trust has already been recorded for November.
Target: >£9.4M
What do the charts tell us?
This metric has failed to reach target this year, the last 2 months have shown a significant drop in performance.

Actions to improve:
In month 7 a comprehensive review was carried out to better reflect deliverability of all the schemes in 19/20. This resulted in a significant reduction on the schemes that were previously earmarked for 19/20 delivery; £4.1m now represents the latest FYE plans.

Total value to be delivered in 19/20 equates to £3.0m; creating a £6.4m pressure. Taking into account all operational underspends and unallocated reserves the majority of the non-recurrent support offsets the gap in CRE delivery. Monthly finance meetings and the bi-monthly CRE meetings will continue to oversee the delivery and development of these schemes on an on-going basis. In November the Executive Team considered a paper prepared by the PMO, setting out an outline approach to support delivery of our 2019/21 Forecast Outturn Position, and commence development of our 2020/21 CRE profile. Approved by the Executive Team, this approach will see corporate and clinical services progressed through a process, supported by the PMO, using national benchmarking and metrics to identify areas of potential CRE. In developing the approach PMO met with members of the Executive Team to identify areas of potential opportunity, and agree the data set and metrics to support identification.

To inform discussions considerations were given to the actions taken by a range of other NHS organisations to develop financial efficiency, together with benchmarking data provided by NHSI/E. At this stage corporate and clinical services have been advised to assume a CRE target of at least 3.9%, recognising that this may change as we finalise our financial plan.
Target: 90%

What do the charts tell us?
We have failed to reach target in the last 6 months, although we have seen some improvement since July.

Actions to Improve:

Bexley: 79% positive (96 out of 122)
There was only one 'wouldn't recommend' response from a patient on Holbrook ward - the respondent did not provide detail regarding what this specifically related to.

The other responses which fall into the 'not recommend' category, were attributed to 'unsure /don't know'. These totalled of 25 people, of which 4 were from Millbrook (43% positive score) and 2 were from Family consultation (33% positive score). The wards feature most highly, as expected (Holbrook 70% positive, Lesney 62% positive), and have contributed to the overall scoring this month. Inpatient MH wards tend not to score highly as these are often are areas of challenge in FFT and can be difficult places for patients to be.

PEG are aware of the results and will be reviewing any recurring themes.

Continued overleaf...
Actions to Improve: continued...

**Bromley:** The declining numbers have been brought to team leaders attention at both quality meetings and senior managers meeting where staff reported numerous problems with introducing the question and its usefulness for service improvement. The decline in figures was noted as a concern and has resulted in an increased focus on FTT and patient experience feedback being targeted in teams. The new FTT approach and reformulated question was discussed at the Bromley quality meeting on 2.12.19 and teams felt the new question made more sense to clinicians. On that basis teams will discuss the new approach with the aim to improve data collection and implementation of learning.

**Greenwich:** Compliance continues to improve from 67.3% in August 2019 to 81.5% in November. Teams continue to give Patients the questionnaire at every opportunity, and PCP and Liaison teams are trialling patient experience questionnaires via text message.
SINGLE OVERSIGHT FRAMEWORK DASHBOARD  
December 2019 - Reporting November 2019 Activity

For further information pertaining to each of these measures, click here:  
"New NHS improvement Single Oversight Framework Document

---

<table>
<thead>
<tr>
<th>Measure</th>
<th>Tally</th>
<th>Display</th>
<th>Admin</th>
<th>Sector</th>
<th>Update</th>
<th>Source</th>
<th>Target</th>
<th>Notes</th>
<th>Score</th>
<th>Status</th>
</tr>
</thead>
<tbody>
<tr>
<td>Early intervention in psychosis (EIP) - 2 week waiting times Monitoring (Waiting)</td>
<td>10615</td>
<td>NHSI</td>
<td>IAPT</td>
<td>Monitor</td>
<td>Yes</td>
<td>IAPT</td>
<td>&lt;=53%</td>
<td>53.9%</td>
<td>N/A</td>
<td>Green</td>
</tr>
<tr>
<td>Inappropriate out-of-area placements for adult mental health services</td>
<td>11134</td>
<td>NHS Digital</td>
<td>IAPT</td>
<td>Monitor</td>
<td>No</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
<td>89%</td>
<td>Green (90-100)</td>
</tr>
<tr>
<td>Referral to treatment for incomplete care pathways</td>
<td>10666</td>
<td>NHS Digital</td>
<td>IAPT</td>
<td>Monitor</td>
<td>Yes</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
<td>4.1%</td>
<td>Red (0-40)</td>
</tr>
<tr>
<td>Access to adult wards of under 16s</td>
<td>10664</td>
<td>NHS Digital</td>
<td>IAPT</td>
<td>Monitor</td>
<td>Local Reporting</td>
<td>Yes</td>
<td>N/A</td>
<td>N/A</td>
<td>0%</td>
<td>Green</td>
</tr>
<tr>
<td>Inappropriate bed days. 880 days in total over the period - September 2019 to June 2020.</td>
<td>10665</td>
<td>NHS Digital</td>
<td>IAPT</td>
<td>Monitor</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
<td>70.0%</td>
<td>Red (0-40)</td>
</tr>
<tr>
<td>Admissions to adult wards of under 16s</td>
<td>10664</td>
<td>NHS Digital</td>
<td>IAPT</td>
<td>Monitor</td>
<td>Local Reporting</td>
<td>Yes</td>
<td>0</td>
<td>0</td>
<td>N/A</td>
<td>N/A</td>
</tr>
<tr>
<td>CPA 7-day follow-up in the last 12 months</td>
<td>10314</td>
<td>HSCIC</td>
<td>IAPT</td>
<td>Monitor</td>
<td>Yes</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
<td>95.2%</td>
<td>Green (85-100)</td>
</tr>
<tr>
<td>CIN alerts for young events</td>
<td>10460</td>
<td>NRS</td>
<td>IAPT</td>
<td>Monitor</td>
<td>Internal</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
<td>100.0%</td>
<td>Green (100)</td>
</tr>
<tr>
<td>CIN alerts onboarding for young events</td>
<td>10659</td>
<td>NHS</td>
<td>IAPT</td>
<td>Monitor</td>
<td>Internal</td>
<td>N/A</td>
<td>3</td>
<td>3.0%</td>
<td>N/A</td>
<td>N/A</td>
</tr>
<tr>
<td>Under-reporting of Patient Safety incidents</td>
<td>10664</td>
<td>NHS</td>
<td>IAPT</td>
<td>Monitor</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
<td>7.0%</td>
<td>Green (0-10)</td>
</tr>
<tr>
<td>Turnover (Annual)</td>
<td>10332</td>
<td>NHS Staff Survey</td>
<td>IAPT</td>
<td>Monitor</td>
<td>Not collected</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
</tr>
<tr>
<td>Sickness</td>
<td>10333</td>
<td>NHS Digital</td>
<td>IAPT</td>
<td>Monitor</td>
<td>Workforce Dashboard</td>
<td>Yes</td>
<td>N/A</td>
<td>N/A</td>
<td>4.6%</td>
<td>N/A</td>
</tr>
<tr>
<td>Staff FFT - % recommended care</td>
<td>10663</td>
<td>NHS Digital</td>
<td>IAPT</td>
<td>Monitor</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
<td>65%</td>
<td>N/A</td>
</tr>
<tr>
<td>Support and compassionate</td>
<td>10334</td>
<td>NHS Digital</td>
<td>IAPT</td>
<td>Monitor</td>
<td>dashboard</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
<td>20.6%</td>
<td>N/A</td>
</tr>
<tr>
<td>Teamwork</td>
<td>10335</td>
<td>NHS Digital</td>
<td>IAPT</td>
<td>Monitor</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
<td>74.3%</td>
<td>N/A</td>
</tr>
<tr>
<td>Inclusion (1) Average of % of the staff believing the trust provides equal opportunities for career progression or promotion</td>
<td>10336</td>
<td>NHS Digital</td>
<td>IAPT</td>
<td>Monitor</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
<td>85.6%</td>
<td>N/A</td>
</tr>
<tr>
<td>Recruitment</td>
<td>10337</td>
<td>NHS Digital</td>
<td>IAPT</td>
<td>Monitor</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
</tr>
</tbody>
</table>

---

[For full details, visit the link provided in the document.]

---

For more information on each measure, visit the [NHS Improvement Single Oversight Framework Document](link).
<table>
<thead>
<tr>
<th>Method of Collection</th>
<th>Current Reporting</th>
<th>Matches Local Reporting?</th>
<th>Target</th>
<th>Nov-19</th>
<th>Comment</th>
<th>Variance</th>
<th>Assurance</th>
</tr>
</thead>
</table>

**Note:** Variance is reviewed on a monthly basis. For Variance - special cause is determined if trend overall is improving or deteriorating. If there is no obvious trend then common cause is applied. For Assurance the metric must have failed to reach target for at least 0 of the last 6 months and is still failing.
**Board of Directors**  
9 January 2020

<table>
<thead>
<tr>
<th>Report Title</th>
<th>Board Operational Performance Report</th>
</tr>
</thead>
<tbody>
<tr>
<td>Author</td>
<td>Iain Dimond Chief Operating Officer</td>
</tr>
<tr>
<td>Accountable Director</td>
<td>Iain Dimond Chief Operating Officer</td>
</tr>
<tr>
<td>Confidentiality/FOI status</td>
<td>Public</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Report Summary</th>
<th>Adult Learning Disability</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>• Atlas House</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Intensive Community Support Team</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• LSEC contract update</td>
<td></td>
</tr>
</tbody>
</table>

| Bexley Care | • Adult Community Services demand and capacity work |   |
|            | • Barefoot Lodge                                      |   |
|            | • CMHT/ Primary Care interface                       |   |
|            | • Adult MH inpatients                                |   |
|            | • Bexley Care service model update                   |   |

| Bromley | • Relocation of services from Yeoman House |   |
|         | • IPS Fidelity Review                        |   |
|         | • RTT for Psychological Therapies            |   |

| Children & Young People | • Specialist Services |   |
|                         | • Universal Services  |   |
|                         | • CAMHS               |   |

| Forensic & Prisons | • ITV documentary on Belmarsh Prison |   |
|                    | • Female Forensic Hostel             |   |
|                    | • Seclusion                          |   |

| Greenwich | • Community Provider Network |   |
|          | • Adult Community Health service developments |   |
|          | • Mental Health service improvements      |   |
|          | • Memory Service                       |   |

<table>
<thead>
<tr>
<th>Purpose (To select purpose, click on relevant choice for drop down box)</th>
<th>Information</th>
<th>To Note ✔</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Approval</th>
<th>Decision</th>
</tr>
</thead>
</table>

**Recommendation**  
The Board is asked to note the operational report.
<table>
<thead>
<tr>
<th>Link to strategic objectives click on relevant choice for drop down box</th>
<th>Quality ✓</th>
<th>Workforce ✓</th>
<th>Sustainability ✓</th>
<th>Partnerships ✓</th>
</tr>
</thead>
<tbody>
<tr>
<td>Link to Board Assurance Framework</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Implications</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Quality</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Financial</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Equality analysis</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Service user/carer/staff</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Adult Learning Disability

Atlas House: Bed Occupancy/Income Generation Challenge

The tables below evidence a trend of reducing occupancy at Atlas House since July 2019. This creates a financial challenge for the directorate associated with achievement of the annual ECR income generation target. Year to date, the current position is break even, however there is currently only one further admission in the pipeline leading up to financial year end.

There are currently no strong potential referrals for Atlas House, with the last referrals all going to the community with additional support, rather than to an inpatient setting. This evidences a positive situation with regard to the provision of appropriate community services but highlights the need to review the Atlas House service in the strategic context in which it is working. An initial meeting with the team to discuss potential demand/need is scheduled for the second week in January.

---

Intensive Community Support Team

The staff for the Intensive Community Support Team are now in post and accepting referrals. Clinical work is underway with service users where it has been identified they would benefit from this intensive support. This intervention includes systemic work (attending and convening network
meetings, staff consultations and family meetings) and Positive Behavioural Support work (setting up and carrying out observations, implementing behaviour monitoring, gathering history and background information). Regular meetings have been set up with the commissioners to review those on the dynamic support registers as well as regular operational/contract review meetings.

**London South East Colleges (LSEC) Contract Update**

The team are in the process of agreeing the on-going services provided to LSEC. The work the team provide is viewed positively and the duration of the renewed contract is proposed to be 3 years. Unfortunately there have been a number of staff resignations recently which has increased the challenge of providing the service.

There has also been an approach from the Learning and Enterprise College in Bexley for a similar service provision, this is being reviewed but with the recognition of the challenges of filling these posts, particularly if the proposal is only for a 1 year agreement.

**Bexley Care**

**Neuro - Update**

The Bexley Neuro team continue to experience staff recruitment issues, resulting in a number of vacancies.

This continues to impact on our waiting times:

<table>
<thead>
<tr>
<th>Team</th>
<th>Total Clients Waiting</th>
<th>Number of Clients 0 -11 weeks</th>
<th>% 0 - 11 weeks of total</th>
<th>Number of Clients 12 -14 weeks</th>
<th>% 12 - 14 weeks of total</th>
<th>Number of Clients 15 -18 weeks</th>
<th>% 15 - 18 weeks of total</th>
<th>Number of Clients waiting over 18 weeks</th>
<th>% over 18 weeks of total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Nov</td>
<td>146</td>
<td>105</td>
<td>71.92%</td>
<td>19</td>
<td>13.01%</td>
<td>10</td>
<td>6.85%</td>
<td>12</td>
<td>8.22%</td>
</tr>
<tr>
<td>Dec</td>
<td>162</td>
<td>115</td>
<td>70.99%</td>
<td>13</td>
<td>8.03%</td>
<td>17</td>
<td>10.49%</td>
<td>17</td>
<td>10.49%</td>
</tr>
</tbody>
</table>

Updates to our mitigation plan are detailed below:

<table>
<thead>
<tr>
<th>Actions</th>
<th>Update</th>
</tr>
</thead>
<tbody>
<tr>
<td>Agency requests submitted to panel to cover vacancies</td>
<td>The panel agreed the request but only able to find someone 3 days a week. The team have reviewed the banding and a new request is being submitted to the agency panel. Provided temporary staffing with off framework agency details to try to facilitate agency placements</td>
</tr>
<tr>
<td>Approached Greenwich team for support with bank or overtime.</td>
<td>Unable to support Bexley</td>
</tr>
<tr>
<td>8A OT working extra hours to support the</td>
<td>8A continues to work additional hours. Our SLT Band</td>
</tr>
</tbody>
</table>
8A has now returned from Adoption leave

Operational Manager (8B) role recruited to and clarity over LCN responsibility

Post holder appointed and due to join Bexley in January

All posts out to advert asap but little or no applicants ie.

Physio 8A just closed for 2nd time with no applicants
Band 8A Physio is out to advert again but for full time post. This will impact on budgets so will create a funding pressure but it’s hoped this may attract more candidates

Neuro is part of the Rehab pathway development to see how we can maximise resources

We are working with estates to find a base to bring together CART and Neuro. Economies of scale in staffing and a remodelled pathway may help to reduce pressure on both teams as there are often duplicate referrals for a patient.

Community SLT - Update

We have been using additional bank shifts to help clear the SLT back log. Whist there is only a small reduction in the overall numbers, we have seen a reduction in the longest wait for a swallow assessment drop from 14 weeks to 3 weeks.

<table>
<thead>
<tr>
<th>Team</th>
<th>Total Clients Waiting</th>
<th>Number of Clients 0-11 weeks</th>
<th>% 0-11 weeks of total</th>
<th>Number of Clients 12-14 weeks</th>
<th>% 12-14 weeks of total</th>
<th>Number of Clients 15-18 weeks</th>
<th>% 15-18 weeks of total</th>
<th>Number of Clients waiting over 18 weeks</th>
<th>% over 18 weeks of total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Nov</td>
<td>98</td>
<td>51</td>
<td>52.04%</td>
<td>7</td>
<td>7.14%</td>
<td>4</td>
<td>4.08%</td>
<td>36</td>
<td>36.74%</td>
</tr>
<tr>
<td>Dec</td>
<td>87</td>
<td>45</td>
<td>51.74%</td>
<td>10</td>
<td>11.49%</td>
<td>3</td>
<td>3.45%</td>
<td>29</td>
<td>33.32%</td>
</tr>
</tbody>
</table>

We continue to engage with the commissioners on increasing funding for this service.

Diabetes – New

The team consists of 1.40 WTE and the caseload has been increasing for a number of years. The table below shows the impact of the increased workload on the clinicians:

<table>
<thead>
<tr>
<th>Avg caseload per month</th>
<th>Total Bexley</th>
<th>Ratio per clinician</th>
</tr>
</thead>
<tbody>
<tr>
<td>19/20</td>
<td>167</td>
<td>119.29</td>
</tr>
<tr>
<td>18/19</td>
<td>108</td>
<td>77.14</td>
</tr>
</tbody>
</table>

In comparison, the Greenwich Diabetes team in 19/20 had a ratio of 56.66 patients per 1.0 WTE clinician, half the Bexley figure. We have highlighted this disparity to the commissioners as part of investment proposals for this year.
Our key risk is that the Band 7 nurse has submitted her request to retire at the end of March 2020 and our remaining Band 6 nurse is not yet a prescriber (which is required for this service). If we are unable to recruit or find an agency person to cover this, it may limit our ability to meet patient need. Our mitigation plans include:

1. Urgent recruitment to the post
2. Liaison with Greenwich over cover arrangements if recruitment is unsuccessful
3. Sourcing agency staff
4. Temporarily creating capacity for our Operational 8B to support the team as she is a Diabetes Specialist

**Podiatry**

We have highlighted to the commissioners the pressure on the podiatry service in Bexley. The team consists of 3.6 WTE and has seen a small monthly increase in the caseload for a number of years. However the complexity of patients’ needs has increased meaning people are remaining on the caseload for longer periods of time. The table below shows the impact of the increased workload on clinicians:

<table>
<thead>
<tr>
<th>Avg caseload per month</th>
<th>Total Bexley</th>
<th>Ratio per clinician</th>
</tr>
</thead>
<tbody>
<tr>
<td>19/20</td>
<td>1773</td>
<td>492</td>
</tr>
<tr>
<td>18/19</td>
<td>1699</td>
<td>472</td>
</tr>
</tbody>
</table>

In comparison Greenwich Podiatry team in 19/20 has a ratio of 284 patients per 1 x WTE per clinician.

The team continue to monitor the impact on how long patients are waiting for follow up appointments.

The SLT, Diabetes and Podiatry challenges are a result of low investment in community services in Bexley in previous years. It is hoped that the creation of the SEL CCG plus the work on a single service specification for community services may help address the lack of funding.

**Mental Health**

**Barefoot**

- The directorate are currently working with the SLP and the new single point of contact; this is creating a good overview of all referrals and intakes thereby ensuring that there is a monitored waiting list of patients in order to minimise voids.
- The directorate are progressing the development of the service as a nurse led unit and further integration with the community mental health rehabilitation service.
CMHT

- Primary Care Plus continues to have a high number of referrals. We are reviewing the relationship with GPs and the main referrers and looking into supporting the highest referring surgeries.
- Alongside other boroughs, the directorate is using Transformation funding to recruit to a post acting as an interface between GPs and Secondary Care with a focus on better management of flows between the two. Allied to this, GP’s are also reviewing their role to see if they could develop a Primary Care Interface role for a GP.

Bexley Care Model Development

A meeting was held in November with GP leads to review our single referral tool. A number of amendments were suggested and the project team is currently scoping these before final sign off from primary care colleagues. These changes will make it easier for GP colleagues to complete the form and for Bexley Care staff to identify the patients’ needs across multiple services.

Senior colleagues attended a Bexley GP Federation engagement event on new ways of working across the PCNs. A second follow up meeting is to be held in late January 2020 in which we will co-present to outline the current community provision and how to enhance integrated working through the new investment in primary care (such as ESP’s).

The new project team structure has been established and people are now in post. A project plan is being developed which will identify new key milestones for the development of the project. These will focus on expanding the current provision via the SPC, maximising the use of the single assessment tool and the creation of the three LCN services (including the estates challenges).

Bromley

Relocation of Yeoman House services

In early 2019 the Trust was given notice that the building lease at Yeoman House was due to expire at the end of December 2019 with no extension being offered. Bromley Directorate had five adult mental health teams based at Yeoman House with other services using space to run clinics, including older people’s mental health services.

This presented a significant challenge in identifying suitable alternative. Potential space was identified for services at the Beckenham Beacon Community Hospital site which the CCG were planning to vacate. Following a period of planning and negotiation, a move there was agreed. Extensive refurbishment was required and, with joint working between the Directorate and colleagues from the Estates Directorate, the works were completed on time.
Staff engagement was undertaken throughout this time and regular meetings held with the staff group. Communication with service users took place over a period of months in order to ensure that all were aware of the new arrangements.

On the 12th and 13th December 2019 all services based at Yeoman House, (with the exception of the Trust Adult ASD / ADHD services which moved to QMH site during the first week of December) moved to brand new, purpose built space at Beckenham Beacon Community Hospital with service continuity maintained throughout. This change now allows people to access mental health services in an improved setting alongside the physical health services already there.

IPS Employment Service Fidelity Review Results

Highly positive results have been published following completion of the first IPS Employment Service Fidelity Review which took place in the summer with an overall rating of ‘GOOD’. The service covers the ICMP, EIP and ADAPT teams across the East and West localities. Key findings were:

- that the Employment Specialists are extremely valued within the clinical teams. The Employment Specialists are integrated in the teams which was seen positively.
- Service users interviewed spoke highly of the support provided by the Employment Specialists especially their ability to focus on individual need, their encouragement and belief that the service users would success. The service users stated that the Employment Specialists had increased their confidence and self belief in finding and sustaining employment
- that the Employment Specialists are person centred and focus on providing a supportive environment to service users and colleagues.
- the service is well supported through strong leadership by the manager Omorlora Cole and the senior team are very supportive of the service provided.

Bromley Psychological Therapies have been reviewing its RTT:

Waiting times for psychological therapies remain an area of focus. These have been contributed to by recruitment issues in ADAPT East and ICMP and OPMH. This remains an issue, however new staff have just commenced in post in ADAPT East. In addition, lead psychologists have undertaken a data cleansing process which has resulted in positive corrections to the data. There is an underlying positive trend in ADAPT East (where the most concerning waits were historically) where the individual therapy waiting list was at 64 in Dec 2018 but has now reduced to 27 due to the instigation of a groupwork programme. A further improvement to the RTT figures for January 2020 is anticipated.
Children & Young People

SPECIALIST SERVICES

ADHD and ASD demand

An ASD pathway learning event took place on Friday 6th December to feedback on the recent QI project and discuss service development initiatives. The day was well received and generated interesting discussion points.

In the Bexley service there is some identified underspend which has been allocated to help maintain the progress made by Dr Jacobs with regard to decreasing the waiting list. In Greenwich MHIS underspend has been identified to support the service in the same way. We are hoping for a decision from both commissioners regarding the submitted business cases in March. Recruitment to these teams remains challenging.

Diabetes

The CYP Diabetes nursing service transferred to QEH (Woolwich) on the 1st December 2019. The service has provided paediatric nursing support to the diabetes multi-disciplinary hospital team since 2012 for Greenwich and 2014 for Bexley. The clinical outcomes for children with diabetes have been reported as excellent and compares well against national data.

Despite the numerous complications regarding the transfer of the service, the community diabetes team have worked with L&G to support a smooth and safe transfer for children and families.

Dietetics

Due to purdah, the tender for the HEN products has been delayed. The evaluation date is now likely to be 21st January 2020.

Bluebell House

Following the staff consultation, the outcome paper and individual staff letters confirming new working arrangements have been sent out. Unfortunately there was a slight delay to the process due to purdah.

All staff have been offered posts within Oxleas, taking into account preferences where possible. The team are currently collating an inventory of equipment to ensure this is allocated to the appropriate teams across Oxleas.

UNIVERSAL SERVICES

Greenwich

Start Well Greenwich tender

The Health Visiting and Children’s Centres tender has been awarded to three local providers: Greenwich Leasure Ltd, Quaggy development trust and Home Start Greenwich. Our bid partner,
Barnardos, intend to apply for a feedback meeting with the commissioners. Relationships with Barnardos remains strong and we would both consider opportunities to work together in the future.

The Children’s Centres have set up a charitable venture, which they have called Start Well Trust. They have not yet named their health provider.

**Young Greenwich tender**

Commissioners chose to halt the initial procurement process and entered into a negotiated dialogue with our Young Greenwich partnership. After two weeks of questions and a review of our submission, we have proposed a service model which Commissioners are going to recommend to the 20th January cabinet meeting. In the meantime we have started mobilising the new service within the constraints of the legal position we are currently in. Relationships with our partners Charlton Athletic Community Trust and Metro Charity remain strong.

**Immunisations contract.** We have agreed to continue to deliver school immunisations from April 2020 to March 2021. We have worked with NHS England on price and we will deliver the new model and seek to make efficiencies during the summer months to meet the budget envelope.

**Bromley**

We have not been awarded the contract for the 0 to 19 integrated Public Health Nursing service. The new service will be provided by Bromley Healthcare from 1st October 2020, so there will be a long mobilisation/transition period.

Work continues to recruit to vacant posts, and the vacancy rate is improving; we are using bank and additional agency staff within available funding to support the service.

The performance against KPIs is improving month on month. We have reached the 90-95% target on three of the five mandated checks and are amber on the other two. This is a significant achievement for a service funded at below the London average and is 20% above the London average on most checks.

**CAMHS**

**Access targets**

Access rates from April – November indicate that Bexley is at 73.8% of the target for this period, Bromley is at 40.3% of the target and Greenwich is at 74% of the target. This position is broadly similar to last year when services achieved the target of 32%. The target for the current year is 34% and with the additional investment from the MHIS funding, it is expected that services will achieve or exceed the target.

**NHSI Review, Bromley /4WW Trailblazer Pilot**

The NHSi team carried out a review of Specialist Community CAMHS and Bromley Y on 30th and 31st October. They returned to Bromley to verbally feedback on their findings on 13th December. We are yet to receive the report. The feedback was detailed and multi-faceted. A prominent finding related to the commissioning arrangements – in particular, the plan for LBB and the CCG to tender the
Bromley Y contract in 2021. This is seen as an obstacle to Bromley Y developing an integrated service with Oxleas CAMHS. The report should be received early in January and we will have the opportunity to respond to the content.

All 4 week wait Trailblazer sites are engaged in NHSi reviews. Anonymised learning from the reviews will be shared at the rolling programme of national Trailblazer conferences, which we are engaged in.

New pathways which will support reduced waiting times have been designed and will be operationalized in February. 6.0 out of 8.2 WTE staff have been recruited. There is an underspend against the budget for the pilot and a plan is in development for this non-recurrent funding to be utilised to improve the informatics capability of the Bromley Y SPA.

**Greenwich Trailblazer Pilot**

This project is being mobilised. Staff recruitment is underway. The Education Mental Health Practitioners are recruited and have commenced their training.

**SLP Provider Collaborative**

A review is due to commence to evaluate the community services which have been developed within the New Care Model. One driver for the review is to explore further alternatives to inpatient provision. Within the scope of the review is the following:-

- Community services - Oxleas DBT, Crisis teams, Tier 3.5 teams in each Trust
- Inpatient services

At the end of the review it will be possible to appraise the options to revise current service models and to develop new ones.

**Forensic & Prison Services**

**Documentary on HMP Belmarsh**

The first part of a two episode documentary on HMP Belmarsh is being screened on 9th January 2020 on ITV. The documentary, which features our healthcare team, has been viewed by the directorate in advance of the screening. Further details are below, taken from the ITV website:

“This brand new two-part documentary series for ITV goes inside the walls of HMP Belmarsh with Ross Kemp to offer a sharp insight into the harsh realities of life behind bars at arguably the country’s most notorious jail.

With cameras gaining full access to the prison in South East London for the first time, Ross went inside the jail over a period of six months to find out what life is like inside the
maximum security lock-up that has housed the country's most dangerous - and infamous - convicts.

Cameras follow Ross as he explores how prisoners and staff cope with high-profile inmates, extremists and common criminals living side-by-side, goes inside the High Security Unit – the only ‘prison within a prison’ in England and Wales - experiences the effect drugs can have on prisoners, and gets an insight into Belmarsh’s efforts to rehabilitate inmates.

He also sees how this complex prison operates as a violent protest unfolds outside, gaining a full-access close insight into life for staff and prisoners while it goes into lockdown.”

Female Forensic Hostel

The contract and lease has been signed with Langley House Trust for the delivery of the new female forensic hostel service at Somerset Villa, Goldie Leigh. The hostel, now known as Mariposa House, will have ten places for women from South London. The CQC will be visiting the site in early January 2020 and, assuming there are no issues with registration, service users will commence trial overnight leave later in the month.

As part of the introduction of this new community capacity we are considering, along with SLP colleagues, how to change the use of existing acute secure bed capacity to meet the needs of the population (both within South London NHS beds and in the independent sector). Any changes will be agreed through the joint Operational Board.

Seclusion

The new seclusion suite adjacent to Burgess Ward at the Bracton Centre is nearing completion. This provides additional seclusion capacity and is able to be used by male and female patients.

Planning for a new seclusion area at Hazelwood Clinic, Memorial Hospital, has commenced with works expected to start in Spring 2020. This is part of the plan to utilise Hazelwood as a low secure admissions facility across South London. There are currently no seclusion facilities for our low secure wards at Memorial.

Greenwich

Adult Community Services

Community Health Services

Alongside Bexley, we continue to work with provider colleagues in SE London in setting up a Community Provider Network to drive forward a work plan to deliver the NHS Long Term Plan expectations. We have also heard back from The NHS National Executive that they have approved the SEL submission as an accelerator site for the 2 hour urgent community response service and we are currently reviewing the draft action plan, work streams and timescales and agreeing the project support, finances and evaluation methods.
The Community Provider Network is an informal partnership and leadership forum for health and social care agencies in SE London. The aim of the Group is to support primary, community, mental health and social care colleagues to work together to oversee and coordinate two major programmes of work: the implementation of the SEL adult community services (ACS) Plan and the implementation of the accelerator bid to establish 2 hour crisis/2 day reablement services to meet national standards by April 2021.

**New Services**

**Home as Priority:** For the last 6 months this work stream has been focusing on expanding the urgent community response in Greenwich and this links closely with the plans above. Greenwich’s Community Urgent Response Service is provided by JET (Joint Emergency Team) which is an integrated team made up of staff from the Royal Borough of Greenwich’s social care team and Oxleas’ community health services and currently provides an assessment service in the community to prevent hospital admission and ED attendance. From January 2020 they will also be able to accept some patients for urgent treatment as well as assessment and from Spring 2020 the team will include consultant support, full-time medical cover, and a nurse prescriber with advanced assessment skills.

**Frailty Pilot:** We are currently finalising the service specification for this work with Oxleas being the main provider. The service is expected to manage a cohort of between 250-500 patients over a 12-month period and the Frailty team will be made up of staff drawn from a range of providers, but working as a virtual team. The aim is to begin the pilot in April with the Riverview Primary Care Network.

**Falls Service:** This service will be provided by the existing Community, Rehabilitation Short Term Assessment Team (CR-STAT). The team will have an additional 5.6 WTE staff who will be able to provide 4 group classes across Greenwich along with specialist assessments and interventions including prevention. This is due to start in April 2020.

**Lymphoedema Service:** The directorate is currently putting together a proposal to set up a service in Greenwich.

**Operational Issues**

**District Nursing:** Due to changes in the GP registration with Care Homes in Eltham, some care homes which the District Nurses support have transferred to Bromley, reducing the caseload numbers in the Eltham North and South Teams. This has resulted in a decision, based on workload and capacity, for the team to be combined and work across Eltham as one team.

**Mental Health Services**

Our service improvement work focusing on the delivery of community mental health continues, with new senior staff in post from January 2020 and additional care coordinators being recruited to. Progress is being made with Lewisham and Greenwich Trust in
developing the operational policy for a new mental health suite at A&E and a review is underway of the space needed to set up a psychiatric decision unit (PDU) at Oxleas House.

We completed the ‘Dr Julian’ pilot (online cognitive behavioural therapy by video call) with 10 selected patients within the IAPT service and, although a small sample, the feedback has been very positive. The total number of DNAs and cancellations was very low, over half the appointments were conducted ‘out of hours’ and feedback from patients was overall very positive. We have agreed in the short term to extend the pilot and continue working with Dr Julian and carry out a waiting list initiative and review the results after 3 months.

**Operational Issues**

**Memory Service:**
Our performance against the percentage target of people diagnosed within 6 weeks has fallen and the average waiting time for diagnosis has increased and is worse than neighbouring boroughs. The main reason being that, during 2019, we have had periods of time where we have experienced staff shortages due to an inability to fill key posts. This has affected the times takes to confirm a formal diagnosis. We have recently been able to recruit an additional nurse prescriber and recruit some additional consultant time and in addition the team is currently undertaking a number of reviews to understand what more can be done:

- The team have met with the NHSE/I clinical programme lead and clinical director to discuss our pathways and carried out a deep dive of the current pathway. They made some suggestions around referral screening, which could have been more efficient, and have now been actioned.

- The team have tightened up their DNA avoidance processes and are collecting data on how many diagnostic appointments have DNA’d each month with the aim of reducing this as much as possible. What we have found so far is that the majority of our DNAs are usually people who cancel the appointment on the day. We are looking at having a standby list and talking to admin about how this might be operationalised. The administration of appointments and DNA’s has been addressed to ensure there is a clearer record of someone’s progress through the memory pathway and all contacts are recorded on RIO.

- A caseload cleansing exercise is continuing looking at: recorded diagnosis - making sure this is being entered on RIO; confirming the diagnosis - checking that this is done properly and dementia is the primary diagnosis; wait times for diagnostic appointments and trying to quantify the current backlog of cases waiting for diagnosis. From that we can then determine how long it will take to clear the list given current resources.

- The team have looked at the patients who have waited an abnormally long time for a diagnosis to investigate why this is and learn from it.
• The team have changed the format of their MDT to ensure there is more opportunity to discuss cases that may require a diagnosis. This aids the process but also acts as a learning opportunity for the whole team. They have also changed their referral screening process to ensure this is more efficient and a better source of data collection.

• From 6 January 2020 the team have scheduled to carry out the audit including: wait from referral to assessment; wait time for scan and results; wait for occupational therapy and psychological interventions; and, once we have the diagnostics, how long the wait is for diagnosis.
<table>
<thead>
<tr>
<th>Report Title</th>
<th>Performance and Quality Assurance Committee Report</th>
</tr>
</thead>
<tbody>
<tr>
<td>Author</td>
<td>Yemisi Gibbons, Non-Executive Director</td>
</tr>
<tr>
<td></td>
<td>Iain Dimond, Chief Operating Officer</td>
</tr>
<tr>
<td>Accountable Director</td>
<td>Iain Dimond, Chief Operating Officer</td>
</tr>
<tr>
<td>Confidentiality/FOI status</td>
<td>N/A</td>
</tr>
</tbody>
</table>

**Report Summary**
The report gives an update on the Trust Quality Performance and Assurance Committee highlights and exceptions from the meetings on 20 November and 18 December 2019.

**Purpose**

Information

To Note  ✓

Approval

Decision

**Recommendation**

To note.

**Link to strategic objectives (click on relevant choice for drop down box)**

- Quality  ✓
- Workforce
- Sustainability
- Partnerships

**Link to Board Assurance Framework**

- BAF 1763 serious incident action closures
- BAF 1776 HBPOS S136 breaches

**Implications**

Briefly outline implications of the recommendations in this report

<table>
<thead>
<tr>
<th>Quality</th>
<th>Performance and assurance</th>
</tr>
</thead>
<tbody>
<tr>
<td>Financial</td>
<td>Performance and assurance</td>
</tr>
<tr>
<td>Equality analysis</td>
<td>Performance and assurance</td>
</tr>
<tr>
<td>Service user/carer/staff</td>
<td>Performance and assurance</td>
</tr>
</tbody>
</table>
IPR Performance

In November, at Trust level, there were three exceptions presented: Performance against closure of actions arising from complaints, 72 hour follow up (self-harm), and Friends and Family Test (Mental Health).

In December, for the first time, the committee were presented with data and an exception report using SPC methodology. Five metrics were showing 'special cause'. Six month CPA Reviews; S132 (Explanation of Rights under the MHA); and S58 (Consent to Treatment under the MHA) were all showing some variation in performance and had failed to reach the target for at least four of the last six months. Response times to complaints and the completion of outstanding actions from complaint investigations were both showing special cause with an improving performance. Exception reports were produced and reviewed by the committee for each of these. A further two areas were highlighted that appeared to demonstrate the beginning of a trend: RTT for AHPs (hitting the target inconsistently) and Friends and Family feedback (FFT) in Mental Health services.

Update on IPR development

At the November meeting the committee heard feedback from two meetings that had taken place with service directorate and informatics colleagues to refine the content of the Trust performance dashboard. It was felt that the current metrics presented within the IPR were not reflective of the breadth of Trust activity and were skewed toward Adult Mental Health. The two underlying principles for the discussions are to achieve more visibility around waiting and access times and patient outcomes. The committee will receive further updates on the work at future committee meetings.

Greenwich Community Mental Health Team Taskforce

In November, the committee received an update from the directorate lead on the Greenwich CMHT action plan which had been developed to address concerns raised by external supported housing providers within the borough and to address variability in standards across the community mental health teams. Fortnightly meetings have been taking place with internal stakeholders and partner agencies to review the progress of implementation. The committee heard that the work was progressing well and, whilst there had been a recent pause in these meetings due to ill health, these were due to reconvene imminently with the next steps being to embed and sustain the improvements as well as link into wider work across all Trust CMHTs to review standards and ensure effective, evidence based care. Staff vacancies and sickness rates in the directorate were acknowledged as an on-going challenge to the embedding of this work. However the Committee noted the picture was improving. It was agreed that a further update would come to the January committee.
S136 Breach Update

At the November committee, the latest Trust S136 breach data was reviewed. It was noted that the numbers of breaches were not increasing however some individual waits for a bed were extremely lengthy and were the result of high levels of bed occupancy during that period of time. Operational approaches to ensuring that there was some capacity to mitigate this risk were outlined. It was agreed that an update (similar to the one presented at the Business Committee in December) should be tabled for the January committee.

Adult Learning Disability Performance and Assurance

In November, the committee received a presentation from the ALD directorate summarising the context of service delivery, their strategy, the governance arrangements in place and performance and quality highlights and challenges. These included work on: Supporting Annual Health Checks; LeDeR – (in particular the completing of reviews and the embedding of learning); Measuring outcomes; service user experience; workforce development; specialist inpatient services; the directorate psychological therapies strategy and patient safety and learning from incidents.

The presentation noted a range of good practice around rolling out of QI projects, participation and learning from the Trust care planning audit, sustaining NICE guidance via the use of Positive Practice Prompts and the involvement of ResearchNet. The directorate noted ongoing challenges including staff vacancies (particularly in therapies), developing IT solutions to obtain an overview of patient outcomes and ensuring that service users could feedback their views about the service as mechanisms such as the FFT question were not always accessible for this cohort. The directorate’s work around intervening in a crisis with service users and the positive relationships fostered with external agencies to manage such situations was also highlighted.

Bexley Care Performance and Assurance

In December, the committee received a presentation from the Bexley Care directorate management team updating the committee on the governance arrangements in place within the directorate plus performance and quality highlights and challenges which currently include work on: Mental Health Friends and Family Test - ensuring consistent feedback rates, understanding and addressing variations between teams/units; Performance against outstanding actions identified from complaints, including developing a buddying system, and requesting further reminders for actions from complaints; RTT: an on-going challenge with staff recruitment and turnover particularly in psychological therapies; Addressing recording issues in EIP/Crisis and Home Treatment Teams; and waiting times for Bexley PCP and reviewing that processes are working to ensure PCP fits into new models of service delivery in Bexley Care.

The committee challenged the directorate around the ongoing issue of staff recruitment in Bexley and its impact on the planning of service delivery, as well as posing challenges for leadership and morale and the directorate were asked if plans were realistically achievable if these issues could not be addressed. The challenge around AHP recruitment was acknowledged, however the directorate felt strongly that changes can still be made to optimise services despite the skills/personnel shortfall. Due to the timing of the meeting there was limited time to discuss some of the recent successes highlighted within the presentation however the committee were asked to note these good news stories.
Quality Priorities

Patient experience

In November the latest complaints response rates against the 30 day target were presented. This data is now collected on SPC charts. Overall performance is currently approximately 35 days although both Bromley and CYP were achieving the 30 day target. It was acknowledged that directorates were working hard to ensure actions arising from complaints are uploaded and closed within agreed timescales.

In December the committee received a report on the use of the Support Network Engagement Tool (SNET) between September and November 2019. The combined Mental Health and Adult Learning Disability services SNET completion rates have been continuously increasing since May 2019, and in November 2019 the Trust achieved a 61% completion rate. However there is variation between teams and inpatient network information is more consistently collected than in the community mental health teams. The Forensics Directorate combined completion rates have been above the Trust target since September 2019, and continue to increase. The combined Adult Community Health services completion rates, while increasing, show a combined completion rate of 28%.

Clinical effectiveness

In December the committee received an update on the monthly care planning audit results. Since the monthly audits began, teams have audited over 11,000 records. It was noted that the DIALOG+ work was improving the personalisation of care plans and that roll out of this work needs accelerating across clinical teams. The committee commented on the positive impact this was having, particularly around refining the management of risk. It was noted that further work, to refine the tool, to ensure it included more risk items (eg physical health care) would be undertaken.

Patient Safety

Safeguarding Children and Adults: It was noted that the two safeguarding committees have been amalgamated to enable an integrated ‘think family’ approach. The first committee met on 28 November 2020.

At December’s committee, it was noted that Greenwich has seen a slight increase in the number of community mental health incidents and the mortality surveillance committee were interested in exploring possible wider factors at play during this period. This is not suggesting that there is a wider contribution rather than to see if there are any patterns of learning themes that can be considered from a wider set of incidents rather than exploring a single incident’s learning. The Mortality Surveillance Committee will review this in February. There will be a particular focus on:

- Bed flow and possible pressures
- Team waiting lists and responses
- Staffing
- Timeliness between referral and assessment
Mortality surveillance: the 2019/20 Q2 report was presented to the committee in December with 287 patients recorded and reviewed at the time of the last mortality surveillance committee. It was noted that these included 43 investigations of deaths ‘not known’ to the Trust. It was explained that these were incidents where the deceased was not open to the Trust at the time, however included so they can be reviewed in RiO to ensure there was no potential learning to be shared in these cases.

**Acute Care Forum**

In December, the committee noted that current priorities for the forum included the finalisation of Rapid Tranquilisation protocols and the refinement of named nurse protocols and the process of allocation of key staff to patients on the wards.

**Older Peoples’ Mental Health Forum**

In December, the committee were updated on the focus of the group on sharing learning from two recent serious incidents, a review of safe staffing data, a discussion of CQC ‘should do’ actions and CQUIN.

**CMHT Forum**

An update was given at the December committee regarding the work of this recently established forum. The workplan of the forum has now been refined and the immediate focus is on using an acuity tool to gain a better understanding, and therefore manage more effectively, caseloads within the teams.

**Quality Accounts Update**

The committee was updated on progress with the quality account indicators (6 overarching quality objectives with 27 quality indicators). At present one of the six objectives has been fully achieved. In terms of the quality indicators, the current performance is:

- Achieved 16 (59%)
- Mostly Achieved 3 (11%)
- Not achieved 7 (26%)
- Awaiting data/ not rated 1 (4%)

The 2020/21 Trust areas of focus will be shared with the committee during the forthcoming months.

**Governance**

**Regulatory & Compliance Update**

The committee noted any CQC Enquiries. It was confirmed that the Provider Information Request had not arrived yet and was not anticipated before the Christmas break. The committee received confirmation that work had been on-going with corporate, directorate and clinical teams in the interim to ensure the Trust was prepared for both when the data request was made and the formal inspection commenced.
**Report Title** | Quarterly Mortality Surveillance Report  
---|---
**Author** | Jane Wells Director of Nursing  
**Accountable Director** | Jane Wells Director of Nursing  
**Confidentiality/FOI status** | Public  

**Report Summary**  
The quarterly mortality surveillance meetings provide assurance that our deaths are being reviewed and satisfy the requirements to report to Boards as a requirement of NHSI.

The attached report provides assurance to the board that wherever a death has occurred that the death is reviewed to establish whether there were any issues with the care and treatment provided. This will help establish if there were any problems that might have contributed to the death, or if the death could have been prevented if things had been done differently.

It covers the period of quarter 2 2019/20, taking into account the previous pattern of monthly reporting to the Board and subsequent reporting via the new Performance and Quality assurance Committee.

The report provides assurance through:
1. Mortality surveillance update
2. Numbers of deaths reviewed
3. Learning from thematic reviews

**Purpose**

(To select purpose, click on relevant choice for drop down box)

<table>
<thead>
<tr>
<th>Information</th>
<th>To Note</th>
</tr>
</thead>
<tbody>
<tr>
<td>√</td>
<td></td>
</tr>
</tbody>
</table>

Approval Decision

<table>
<thead>
<tr>
<th>Information</th>
<th>To Note</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Recommendation

The Board is asked to note the quarterly report confirming assurance with expectations nationally for reviews of deaths in the organisation.

**Link to strategic objectives** (click on relevant choice for drop down box)

<table>
<thead>
<tr>
<th>Quality</th>
<th>Workforce</th>
<th>Sustainability</th>
<th>Partnerships</th>
</tr>
</thead>
<tbody>
<tr>
<td>√</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Link to Board Assurance Framework</td>
<td>This relates to learning from incidents risk</td>
<td></td>
<td></td>
</tr>
<tr>
<td>----------------------------------</td>
<td>---------------------------------------------</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Implications</th>
<th>Briefly outline implications of the recommendations in this report</th>
</tr>
</thead>
<tbody>
<tr>
<td>Quality</td>
<td>Learning and improving practice</td>
</tr>
<tr>
<td>Financial</td>
<td>Learning and improving practice</td>
</tr>
<tr>
<td>Equality analysis</td>
<td>Learning and improving practice</td>
</tr>
<tr>
<td>Service</td>
<td>Learning and improving practice</td>
</tr>
<tr>
<td>user/carer/staff</td>
<td>Learning and improving practice</td>
</tr>
</tbody>
</table>
1 Mortality Surveillance Committee

The Trust Mortality Surveillance Committee is held monthly and reviews all deaths that have occurred in the preceding month, reporting monthly to the Performance and Quality Assurance Committee. The purpose of the committee is to provide assurance that wherever a death has occurred that the death is reviewed to establish whether there were any issues with the care and treatment provided. This will help establish if there were any problems that might have contributed to the death, or if the death could have been prevented if things had been done differently. Deaths are classified according to an expected / unexpected and natural / un-natural classification and the level of investigation is discussed. The findings of serious incident reviews into deaths are shared and thematic reviews undertaken.

1.1 Progress meeting national requirements

The National Learning from Deaths – a Framework for NHS Trusts and Foundation Trusts in identifying, Reporting, Investigating and Learning from Deaths in Care was published in March 2017. The Trust has met the core requirements of the guidance. Our policy on learning from deaths, including involving families and carers, is publically available on our website along with the national template dashboard reporting deaths each month: http://oxleas.nhs.uk/freedom-of-information/mortality-surveillance-data. Serious incident reviews of deaths use structured judgement reviews of possible avoidability.

1.2 Reconciliation of deceased data between national spine and RiO.

As a Trust we receive regular updates from the NHS national spine of all NHS patients on the deaths of patients known to Oxleas. It is important that we act upon this information to ensure that our clinical records are up to date and that where appropriate, information about deaths not already known to us are investigated. We now have quarterly data providing a summary of deaths recorded on the spine, Datix and RiO and gaps accessible via both a live and a committee reporting iFOx programmes.

2 Numbers, classification of deaths undertaken

During the year to date the numbers of patients who died which occurred during the reporting period who were recorded on Datix and reviewed at the time of the mortality surveillance committee were:

<table>
<thead>
<tr>
<th>Quarter</th>
<th>2018/19</th>
<th>2019/20</th>
</tr>
</thead>
<tbody>
<tr>
<td>Quarter 1</td>
<td>286</td>
<td>224</td>
</tr>
<tr>
<td>Quarter 2</td>
<td>263</td>
<td>287</td>
</tr>
<tr>
<td>Quarter 3</td>
<td>263</td>
<td>-</td>
</tr>
<tr>
<td>Quarter 4</td>
<td>256</td>
<td>-</td>
</tr>
</tbody>
</table>

These have all been subject to a case review by a clinical reviewer.

The number of deaths in which a case review or investigation was carried out which we judge to be as a result of the investigation were more likely than not to have been due to problems in care provided:

<table>
<thead>
<tr>
<th>Quarter</th>
<th>2018/19</th>
<th>2019/20</th>
</tr>
</thead>
<tbody>
<tr>
<td>Quarter 1</td>
<td>1 (Score 4 Possible avoidable but not very likely less than 50:50)</td>
<td>2 Score 6 (definitely not avoidable), 1 Score 5 (Slight evidence of avoidability), 1 Score 4 (Possible avoidable but not very likely less than 50:50)</td>
</tr>
</tbody>
</table>
likely less than 50:50), 2 not due to be completed at the time of writing the report.

<table>
<thead>
<tr>
<th>Quarter 2</th>
<th>2 (Score 4 and Score 5 Slight evidence of avoidability)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Out of 16 reports 6 were not due to be completed at the time of writing the report. Of the remaining 10 reports 8 score 6 (definitely not avoidable) and 2 score 5 (slight evidence of avoidability).</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Quarter 3</th>
<th>12 (8 Score 6 definitely not avoidable, 2 Score 5 slight evidence of avoidability and 2 Score 3 Probably avoidable more than 50:50)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td><strong>Deaths Expected / Unexpected Natural/ Unnatural by Directorate (at point of presentation to the Mortality Surveillance Committee):</strong></td>
</tr>
<tr>
<td></td>
<td>EN1 Expected Natural: Death was expected to occur within an expected timeframe. e.g. People with terminal illness. These deaths are unlikely to be preventable.</td>
</tr>
<tr>
<td></td>
<td>EN2 - Death was expected but were not expected to happen in the timeframe. e.g. Someone with cancer or liver cirrhosis who dies earlier than anticipated.</td>
</tr>
<tr>
<td></td>
<td>UN1 - Unexpected death which are from a natural cause e.g. Sudden cardiac condition or stroke.</td>
</tr>
<tr>
<td></td>
<td>UN2 - Unexpected death from a natural cause but which didn’t need to be e.g. Some alcohol dependency and where there may been care concerns.</td>
</tr>
<tr>
<td></td>
<td>UU - Unexpected deaths which are from unnatural causes e.g. Suicide, homicide, abuse or neglect</td>
</tr>
</tbody>
</table>

There were 656 deceased patients on the NHS spine in quarter 1 who had contact with Oxleas ‘services or still had an open referral. These are all being reviewed for completeness and to decease on Rio and the spine.

<table>
<thead>
<tr>
<th>EN1</th>
<th>EN2</th>
<th>UN1</th>
<th>UN2</th>
<th>UU</th>
<th>Unable to classify</th>
<th>Out of scope</th>
</tr>
</thead>
<tbody>
<tr>
<td>6</td>
<td>3</td>
<td>2</td>
<td>1</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
</tbody>
</table>

**Mazars Classification Framework (Quarter 2)**
There were 260 deaths identified on the NHS national spine and Rio with no death date recorded, 111 had an open referral and not recorded as deceased. These are all being reviewed and the date of death recorded for completeness.

3.1 Learning from thematic reviews

LeDeR – completed review case learning - Current learning themes:

1. Increased knowledge outside of Learning Disabilities about the physical health presentations and care of people with Learning Disabilities so that appropriate care and support can be provided, including the need for reasonable adjustments and preventative work where necessary. Services to refer in a timely way to specialist ALD services where necessary.

2. To achieve this, Learning Disabilities Link nurses to be in place for GP surgeries/Local Care Networks to raise awareness of Community Learning Disabilities Teams and services and to support practices to support people with Learning Disabilities including with Annual Health checks. Quality Improvement project is in place initially in Bromley Learning Disabilities nursing to be expanded to other teams. There is a Health Facilitation post in Greenwich which will be focussing on this learning.

3. Capacity assessments to be routinely completed and recorded for all clients receiving ‘treatment’ and when significant decisions are made. This includes consent to treatment. To achieve this, acute, primary and community based health professionals to receive training about Mental Capacity Act and Best Interest frameworks and its application (plans to be agreed).

4. Coordinated care approach within Learning Disabilities Team service so approach is streamlined and client does not need to retell their ‘story’ and health and social care staff liaise and work together at all times. To achieve this, clear communication processes and integrated reviews/systems need to be in place as well as the use of recognised systems such as hospital passports and ‘Black books’. Further awareness training and support to be offered by the Learning Disabilities teams so that all staff involved are aware of the systems in place for people with Learning Disabilities and that these are read and followed as part of the client’s care plan. Training has been planned for PRU for November and will be planned for QEH once the new Acute liaison nurse is in post (November 18). ALD Acute liaison nurses have made many significant contributions to care when people have been admitted to hospital. These posts need to be in place and embedded into the acute care settings.

5. Evidence of poor quality or lack of discharge planning meetings has been identified. Acute services need to ensure that robust planning/discussions are held and recorded for all inpatients with Learning Disabilities prior to discharge involving the local Learning Disabilities Teams and other agencies. In the Princess royal University Hospital the Clinical Nurse Specialist for Learning Disabilities is to re-launch the protocol for patients with Learning Disabilities through a Learning Disability Policy.

Supporting bereaved families

We have reviewed the Learning from Deaths: guidance for NHS Trusts on working with bereaved families and carers (NQB NHSI July 2018) A resource has been made available on 23 April 2019: [http://oxleas.nhs.uk/advice-and-guidance/information-for-families-and-c/families-bereavement/](http://oxleas.nhs.uk/advice-and-guidance/information-for-families-and-c/families-bereavement/). In quarter 2 we reviewed our involvement of families in investigations. There is good evidence that families have been involved in the RCA process in all services with the exception of prisons which will be explored further and recorded in investigation reports.

Review of deaths under 12 months of age April 2018 – September 2019

The majority of reported deaths were a result of prematurity/complications associated to prematurity or congenital abnormalities. These deaths occurred within the hospital environment. The review does not give detail around any prior maternal symptoms leading up to the event to ascertain whether there were any missed opportunities for the mother to seek medical advice. here are 2-3 deaths where there were either co-sleeping or poor sleeping practices and therefore services must still continue to provide appropriate sleep safety advice with consideration of how this education can also reach fathers who may not be present at post-natal contacts
Review of learning from Local Safeguarding Children Case reviews

The learning from our Safeguarding Children Reviews was shared. The common themes were identified as areas of record keeping and documentation, confidentiality and information sharing, formulation of analysis and rationale for decision making. Practitioners are encouraged to utilise professional curiosity when undertaking assessments and risk assessments in order to prevent over-reliance on parental reports. Assessments and interventions must include considerations to the child’s needs, safety and their lived experiences, practitioners are encouraged to hear and listen to their voices. Babies and very young children are inherently vulnerable due to their dependency and fragility.

The majority of cases summarised in this report feature a level of neglect through non engagement with services, disguised compliance and/or limited awareness of signs and symptoms of adolescent neglect. Gaps in understanding the impact of parental mental health on children, parenting and family functioning are also highlighted. In 6 cases, there is little or no consideration to the role of fathers whether they are engaged with professionals or not. Think Family approach to safeguarding is advocated.

The learning has informed the safeguarding children priorities for 2019/10.

Thematic review of deaths in psychosis teams

In May 2018 the CQC published a brief guide; Physical healthcare in mental health setting which stated that people with severe mental illness have a substantially lower life-expectancy than the general population. Therefore, it is essential that staff in mental health settings meet patients’ physical as well as mental healthcare needs. The World Health Organisation provided detailed information on the premature death among people with severe mental disorders which stated that the life expectancy of patients with severe mental disorders is 10-25 years less than the general population. The vast majority of these deaths are due to chronic physical medical conditions such as cardiovascular, respiratory and infectious diseases, diabetes and hypertension. Suicide is another important cause of death. The medical conditions experienced by this group are associated with preventable risk factors, such as smoking, physical inactivity and side effects of psychiatric medication.

As a response to this it was agreed that a 2 year thematic review of the deaths of patients aged between 45-55 years old who were under the care of a psychosis team at the time of their death would be carried out. The review will try and identify any risk factors and themes as well as capture information on the patients known physical health problems to ascertain if there was a link to the cause of death.

During the period of 01/04/2017-31/03/2019 there were 94 deaths that were subject to a comprehensive investigation. Of the 94 deaths, 26 patients (28%) were between 45-55 years of age and of these patients 7 (27%) were under the care of an Intensive Case Management for Psychosis (ICMP) team.

Of the 26 cases 9 (35%) had evidence of drugs and/or alcohol in the toxicology result at post mortem, 4 (15%) were natural causes, 3 (11.5%) were unascertained and a further 3 (11.5%) remain under investigation. It was not possible to find any links between an individual’s known physical health condition and their cause of death. There was also no correlation between the leading cause of death in the national data and the deaths that were reviewed as part of the Oxleas thematic review however it is noted that the age ranges differ.

Learning from Serious Incidents

Learning from Quarter 4 serious incidents

Lesson 1
Risk Assessments
To continue to implement the trust wide training for clinical teams to ensure the formulation of risk for all
patients within their care.

**Action taken:** STORM training is being completed across the Trust. At present the Trust are recruiting a full time STORM trainer.

**Assessment of the impact of the actions:** Full time STORM trainer has been recruited and is now rolling our a two year programme to train staff in STORM.

---

**Lesson 2**

**Physical Health**

Care plans must include comprehensive and detailed information relating to patients physical health and the interventions required.

**Action Taken:** Physical health audits are taking place on the wards as team are moving from MEWS to NEWS. NEWS improves the detection and response to clinical deterioration in adult patients.

**Assessment of the impact of the actions:** All wards are now using NEWS2 and regular audits are maintained with support for teams where required.

---

**Learning from Quarter 1 serious incidents**

---

**Lesson 1**

**Crisis, relapse and contingency plans.**

Team managers must ensure that Ifox is reviewed on a weekly basis to ensure that Crisis, relapse and contingency plans are completed.

**Action taken:** Managers to review Ifox weekly and review the quality of crisis, relapse and contingency plans in supervision.

**Assessment of the impact of the actions:** This has been established as regular practice for managers.

---

**Lesson 2**

**Resuscitation Training**

Staff must be trained in using all the resuscitation equipment that they would be expected to use on site. This training should include unpacking a resuscitation bag from the start of an incident to ensure the appropriate equipment is available for use.

**Action plan:** The Trust have recruited a resuscitation officer to support with training and monitoring of resuscitation equipment.

**Assessment of impact of actions:** Services have been completing ‘drop the dummy’ sessions with staff in practice as well as proving ‘what’s in my resuscitation bag’ sessions with staff to build confidence.

---

**Learning from Quarter 2 serious incidents**

---

**Lesson 1**

**Tele-triage assessments**

Team managers must ensure that all staff completing tele-triage assessments have received the required training and implement standards in relation to what is expected to take place during an assessment.

**Action taken:** Team managers to review the quality of assessments as part of clinical supervision.

**Assessment of impact of actions:** To be updated in Q3.

---

**Lesson 2**

**Risk Assessments**

Risks must be fully assessed at the point of assessment and documented in correct form on RIO.

**Action taken:** To be reviewed as part of clinical supervision and a review of operation standards to take place.

**Assessment of impact of actions:** To be updated in Q3.
Report Title | Safeguarding Adults and Safeguarding Children Annual Reports 2018 - 2019  
Author | Ida Bradford Head of Safeguarding Children and Stacy Washington Head of Safeguarding Adults  
Accountable Director | Jane Wells Director of Nursing  
Confidentiality/FOI status | Public

Report Summary

The safeguarding annual reports provide assurance of compliance with local multi-agency guidelines, sections 42 to 46 of the Care Act 2014 and the fundamental standards in relation to safeguarding described in the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014: Regulation 1 and provides evidence of how we fulfill our responsibilities in relation to Section 11 of the Children Act 2004.

The Board are asked to note these reports.

Safeguarding Adults Annual Report – highlights

The safeguarding adult’s annual report was received and agreed by the Safeguarding Adult (SGA) Committee in August 2019. The report informs the trust board of safeguarding adult’s activity in 2018-19 and includes 3 case studies of safeguarding adults work completed by trust staff during that time.

Highlights are;
- The SGA team was increased by the introduction in February 2019 of a safeguarding adults specialist practitioner post at band 7
- Prevent awareness and the Workshop to Raise Awareness of Prevent (WRAP) training remains above the NHSE target
- We have fully engaged and worked with partner agencies on Safeguarding Adult Reviews (SAR’s) and Domestic Homicide Reviews (DHR’s) in all 3 boroughs.
- Mental Capacity Act (MCA) training and policy updated.
- Following publication of the intercollegiate guidance for safeguarding adults training we have successfully launched level 3 face to face safeguarding adult training.
- SGA forms on RiO have been updated and a new ifox report function went live. Raising of safeguarding adults concerns has significantly increased.
- SGA team completed quarterly quality audits of SGA work.
- Updated our SGA intranet pages to include safeguarding adult reviews.
- We developed “Safeguarding superstars” to identifying exceptional practice.
- Presented our Safeguarding Adults at Risk Audit Tool (SARAT) to Greenwich and Bexley Safeguarding Adults Boards.
- We have been key members participating in the 3 boroughs Safeguarding Adult Boards and their sub groups.

**Priorities for 2019/2020:**

- Continue to promote the use of the RiO safeguarding forms particularly with community health services and work with the RiO Transformation Team to make forms more user friendly to improve accuracy and avoid human error.
- Remove SGA form 3 from RiO and amend process and flow chart accordingly.
- Improve accuracy of the SGA data for CCG’s and Local Authorities by borough through use of iFox and to do further data analysis to identify trends in the data generated. Continue to expand the use of Datix to effectively triangulate information on all safeguarding work in the organisation.
- To evaluate the Trusts face-to-face training workshops (3 versions) and E-learn package for safeguarding adults for Trust staff following feedback.
- To improve working relationship with the Patient Safety Team and the PALS and Complaints Team to ensure that safeguarding adult concerns are identified as part of any investigations.
- To ensure regular and appropriate representation from Oxleas staff at all SABs and subgroups (as required).
- Develop a SAR escalation process due to increasing numbers of SAR’s and DHR’s being seen across the organisation, to co-ordinate the roles for corporate and directorates involvement in process and to embed actions and learning.
- To develop Enquiry Officer training in-house.
- To continue to work and include safeguarding adults in the Trust’s Sexual Safety work stream.
- Continue to roll out “Safeguarding Superstar” using the cases for staff training and on a developed training page on the Trust intranet.
- Closer working with the Safeguarding Children Team – to hold a joint Committee in 2019-20 and linked up training, especially with regard to domestic abuse, Prevent and Modern Slavery and to plan to hold a joint event.

**Safeguarding Children Annual Report – highlights**

Section 11 of the Children Act 2004, places a duty upon Oxleas NHS Foundation Trust to ensure its functions are discharged with regard to the need to safeguard and promote the welfare of children. We do this by:

- Having a clear line of accountability and governance within and across the trust and provision of services designed to safeguarding and promote the welfare of children
- Having clear priorities for safeguarding and promoting the welfare of children underpinned by a key policy and relevant procedures that are founded in legislation, national and local guidance.
- Having procedures for dealing with allegations of abuse against members or staff, safer recruitment processes and whistleblowing policy.

**Safeguarding Children Strategy**

Oxleas vision is to ensure safeguarding and promoting the welfare of children is embedded across every directorate and in every aspect of work. Underpinned by the Think Family approach, children and young people should be considered in all interactions with their carers and adult service users. The welfare of children must be of a paramount consideration.

The strategy was reviewed and updated in April 2017 and comprises 7 areas:

- Effective safeguarding children frameworks
- Developing knowledge and skills
- Mainstreaming safeguarding children
- Learning from experience
- Strengthening partnership working
- Promoting early help for children and families
- Engaging with service users

**Highlights are;**

- We promoted the use of the new Safeguarding RiO forms in children’s and adult services.
- We reported an improved safeguarding children data set.
- We raised awareness of and increase clinicians’ confidence in respect of recognising and responding to neglect Child Sexual Exploitation (CSE) and female genital Mutilation (FGM).
- We raised awareness of the particular vulnerabilities of children under 1 year of age, safer sleep and abusive head trauma.
- We embedded a ‘Think Family’ approach in adult focused services so that children in the adult client network are identified and the needs of the child are always considered.
- We continue to promote a culture of learning, to set up joint learning events for adult and children’s services.

**Priorities for 2019/2020**

- Basic safeguarding and child protection practice across services underpinned by the Think Family approach
- Perinatal mental health and vulnerabilities of under 1’s
- Children with specific vulnerabilities (including contextual safeguarding) and complex health needs
- Adolescent neglect and emotional wellbeing with focus on self-harm
- Continue to promote culture of learning that arises from child safeguarding reviews, audits and inspections

### Purpose

**(To select purpose, click on relevant choice for drop down box)**

<table>
<thead>
<tr>
<th>Information</th>
<th>To Note</th>
</tr>
</thead>
</table>

### Approval Decision

Approval | Decision

### Recommendation

*Clear outline of what the committee is being asked to agree/discuss/note. Items for information will not allocated time for discussion within meeting.*

### Link to strategic objectives

**Link to relevant choice for drop down box**

<table>
<thead>
<tr>
<th>Quality</th>
<th>Workforce</th>
<th>Sustainability</th>
<th>Partnerships</th>
</tr>
</thead>
</table>

### Link to Board Assurance Framework

<table>
<thead>
<tr>
<th>Quality</th>
<th>Safeguarding</th>
</tr>
</thead>
<tbody>
<tr>
<td>Financial</td>
<td>Safeguarding</td>
</tr>
<tr>
<td>Equality analysis</td>
<td>Safeguarding</td>
</tr>
<tr>
<td>Service user/carer/staff</td>
<td>Safeguarding</td>
</tr>
</tbody>
</table>
Safeguarding Adults Annual Report

2018 - 2019

Author: Stacy Washington – Head of Safeguarding Adults & Prevent

Contributions:
Amanda Shoesmith, Safeguarding Systems and Administration Officer
Andy Warren, Safeguarding Adults Specialist Practitioner
## Contents

1. Introduction / Executive Summary ................................................................. 3
2. Workforce Recruitment and Development .................................................. 5
3. Performance Data Set / Audit ...................................................................... 9
4. External Partnership Engagement ............................................................... 11
5. Case studies ................................................................................................. 13
6. Future Objectives ......................................................................................... 16
7. Appendix A .................................................................................................. 20
8. Appendix B .................................................................................................. 21

1.
Introduction / Executive Summary

The purpose of this report is to inform the Trust Board of the safeguarding adult activities undertaken within the organisation for the year 2018-2019. It aims to provide assurance of compliance with local multi-agency guidelines, sections 42 to 46 of the Care Act 2014 and the fundamental standards in relation to safeguarding described in the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014: Regulation 13.

This is the Third Annual Report for Safeguarding Adults produced by Oxleas NHS Foundation Trust.

Governance and Accountability

The Organisation

We provide a wide range of health and social care services in South-East London, specialising in community health, mental health and learning disability services. We have a workforce of around 3,800 people including many highly-skilled health and social care professionals. We have over 125 sites in a variety of locations across the London Boroughs of Bexley, Bromley and Greenwich and Prison services into Kent.

Our services include a range of physical health services to adults and children in the community in the boroughs of Bexley, Bromley and Greenwich. These range from health visitors working with the very young to district nurses and therapists meeting the physical health needs of older people.

We have been the main provider of specialist mental health care in Bexley, Bromley and Greenwich for more than ten years and have developed a comprehensive portfolio of services in community and hospital settings. We also provide specialist forensic mental health care across South East London and Kent Prisons. We also provide adult learning disability services in Bexley, Bromley and Greenwich.

Safeguarding Team Structure

In the autumn 2018 the Trust’s Executive Team reviewed the Safeguarding Adults (SGA) resource for the organisation and agreed to recruit a safeguarding adults specialist practitioner to the team, Andrew Warren was recruited and started in February 2019, increasing the SGA resource to 2 WTE allowing the team to provide specific support and training to staff working in each of the Trust’s three boroughs.
Within the organisation there are also 3.0 WTE Heads of Social Care who work in each of our three boroughs who contribute to Safeguarding Adults work.

**Organisational Leadership**

- The Chief Executive has overall accountability for safeguarding within the organisation. The Director of Nursing is the Executive Lead for safeguarding adults and children and reports to the Trust Board in this area of responsibility.

- The Head of Safeguarding Adults & Prevent takes a strategic lead across the Trust for the management and monitoring of practice in line with the requirements of national safeguarding procedures and is the organisation’s lead for Prevent.

- Within our mental health services, the Heads of Social Care provide local operational leadership in relation to safeguarding adults.

- The Trust has a Consultant Psychiatrist who is the Clinical Lead for Mental Capacity Act (MCA).

- The Trust has a Head of Mental Health Legislation who leads on MCA and Deprivation of Liberty Safeguards (DoLS).

- The Safeguarding Adult’s Team has a part time data analyst and administrative support post shared with the Mental Health Legislation Team which is a 0.6 WTE role.

**Safeguarding Adults Committee**

- The Trust has a quarterly Safeguarding Adults Committee, chaired by the Director of Nursing and attended by relevant staff from within the organisation and representatives from the three Local Authorities and Clinical Commissioning Groups (CCGs).

- The Safeguarding Adults Committee is a sub-group of the Safety Committee which reports to the Trust Quality Board, ensuring that relevant connections are made across the domains of patient safety, patient experience and clinical effectiveness.

**Risk Register**

The Trust reviews its risk register as part of the Safeguarding Adults Committee; at quarter four of 2018-19 the organisation had no current risks on the register.

**Policies and Procedures**

- The Trust Safeguarding Adults Guidance was published in April 2016 and updated in 2018 to reflect changes in the Safeguarding Adults Team and processes within the organisation. It was ratified at the November 2018 Safeguarding Adults Committee and was then made available for all staff. Following the publication of the reviewed Pan London Guidelines in April 2019 we will be further reviewing our own policy to take account of this new guidance.

- The Trust guidance is applicable to all Oxleas staff and outlines the statutory responsibilities of the organisation, identifies the governance arrangements within the organisation and provides clarity for staff on their duties and responsibilities when they have safeguarding concerns.
In addition to the Safeguarding Adults Guidance there are a number of Trust policies in place which have a relationship with safeguarding. These include:

- Prevent Guidance for staff
- Mental Capacity Act 2005 policy
- Deprivation of Liberty Safeguards policy
- Domestic Abuse & Violence policy and procedures
- Safeguarding Children policies and procedures
- Disciplinary policy, procedure and rules
- Mandatory Training policy
- VIP, Celebrity and Media Access policy

All policies within the Trust are aligned to a governance group which ensures that they are monitored, regularly reviewed and updated where necessary.

2. Workforce Recruitment and Development

Safeguarding Training Activity

Prevent

The NHS England Prevent Training and Competencies Framework have been developed to provide clarity on the level of training required for healthcare workers. It identifies staff groups that require basic Prevent awareness and those who require attendance at Workshops to Raise Awareness of Prevent (WRAP) with the target of training 85% of Oxleas registered staff by July 2018.

The Trust uses Home Office accredited trainers to deliver WRAP across the organisation and at year end the Trust had a 98.5% compliance rate for basic awareness and 95.5% compliance with attendance at WRAP.

We are maintaining our compliance by holding monthly face-to-face WRAP sessions and have also rolled out the Home Office accredited e-Learning course for mental health and community health staff on our learning platform which continues to receive good feedback.

MCA and DoLS

The Trust provides both face-to-face and e-Learning sessions for staff in relation to the MCA and DoLS. The e-Learning sessions are mandatory for all professionally registered staff. Newly qualified nurses attend a MCA and DoLS session as part of their preceptorship programme. At year end the Trust reported 96% compliance with the e-Learning requirements.

In 2019 a decision has been taken to improve MCA training by updating the Trust policy to ensure all eligible staff complete MCA and DoLS training every three years and not just as a one-off; training is on trajectory.

Safeguarding Training

In 2018 the Trust reviewed and updated its Safeguarding Adults training in line with the Intercollegiate Guidance published in August 2018.

We had developed a basic awareness e-Learning package which covers both safeguarding adults and children. This learning is mandatory for all staff who do not have direct client contact. The programme covers the law in relation to safeguarding, types of abuse (including domestic, modern
slavery and radicalisation) and addresses all of the knowledge and skills identified for level 1 training in the Intercollegiate Document.

We also had developed a Safeguarding Adults e-Learning programme covering the law in relation to safeguarding, types of abuse (including domestic, modern slavery and radicalisation), how to raise concerns and maintain adequate records. On review it was found that the programme addresses core requirements across levels 2 and 3 in the Intercollegiate Document and its completion is mandatory for all staff who have client contact.

The Intercollegiate Document Adult Safeguarding: Roles and competencies for health care staff published by the RCN sets out guidelines for training at all levels and gave clear guidance on requirements for level 3 training and face-to-face specifics. It was agreed through the SGA Committee that our training implementation for level 3 and its reporting would commence from April 2019 with the Intercollegiate Guidance giving us until 2021 to be fully compliant.

Our level 3 face-to-face training option rolled out from April 2019 with specific versions for mental health staff, community health staff and for managers. The sessions are half day workshops facilitated by the SGA team covering the law, abuse types, information sharing, how to raise a concern, SGA process and record keeping in RiO. It also looks at domestic abuse, modern slavery and self-neglect & hoarding in detail and provides attendees with their three year Prevent update. We also cover the role of Safeguarding Adult Boards and Safeguarding Adult Reviews (SAR’s) including actions from SAR’s completed in the organisation. The course provides staff with time to look at real life cases and to get information about how to deal with safeguarding cases in practice.

Within our integrated teams, appropriate staff are able to access additional safeguarding training via the Local Authority – mainly Safeguarding Adult Manager and Enquiry Officer training. Each Local Authority has different levels of training and this is provided and recorded in different ways so we are unable to report accurately on numbers of staff who have completed this training.

We monitor compliance with current Trust policy quarterly providing data to CCG’s and to the SGA Committee, policy requires all staff to complete Safeguarding Adults learning at a minimum of a 3-yearly basis.

At the end of Q4 2018-19 Safeguarding Adults training compliance levels in the Trust stood at:

- Level 1 – 98%
- Level 2 – 97%
- Level 3 – not available (Q1 19/20 data shows us at 93% compliant)
- Level 4 – 100%

Domestic abuse awareness is included in our safeguarding adult’s awareness training at levels 1 and 2 and is included in our level 3 training. Staff are also able to access a dedicated E-learn package on domestic abuse at level 3.

**Clinical Supervision / Appraisals**

The Trust supervision policy sets out minimum expectations in relation to supervision which is monitored and reported to the Trust Board. The expectation is that all staff will receive a minimum of one hour supervision on a six-weekly basis. The Trust compliance rate with this expectation at the end of 2018-19 was 78% which is just below the agreed threshold level for compliance of 80% for the organisation. This figure was low due to a large number of annual leave being taken in the Trust in March due to the timing of Easter, the compliance reached over 80% the following month. The policy states specifically that Safeguarding concerns and cases are expected to be routinely discussed as part of the supervision session.
All staff are required to have an annual performance development review/appraisal. Compliance with this is also monitored and reported to the Trust Board; at year end the rate was 89%.

**Safe Recruitment Processes and Assurances**

The Trust recruitment and selection policy outlines the Trust’s approach to recruitment. As a provider of NHS services the Trust is required to comply with the NHS Employment Check Standards. The standards apply to all individuals engaged in paid or unpaid work within the NHS.

The Recruitment Team adhere to standard operating procedures in respect of the six standard pre-employment checks which cover:

- Identity
- Right to work
- Professional registration and qualifications
- Employment history and references
- Disclosure and Barring Service checks
- Work health assessment

In addition and where required, assessments will be undertaken to ensure that candidates meet the requirements of the fit and proper persons test.

Compliance with the recruitment processes is monitored by the recruitment team. Regular reports are produced for the Head of Workforce and HR detailing how many candidates have not successfully completed the pre-employment checks process and the actions taken.

The Trust’s Temporary Staffing Office ensures that any agency supplying staff to the Trust has provided evidence that the six employment checks are in place as part of their recruitment processes.

All managers involved in recruiting staff are required to complete safer recruitment and selection E-Learning. Compliance with this training is monitored monthly and at year end 2018-19 was reported at 97%.

Oxleas has a designated senior HR professional to ensure arrangements are in place with regards to the management of allegations against staff. The Head of Safeguarding Adults meets quarterly with the HR lead to discuss cases.

**Safeguarding Learning Events**

We did not hold any Safeguarding Adult specific events in 2018-19 but are planning a possible joint event with the Safeguarding Children’s Team in 2020. The Safeguarding Children Team held a learning event in 2018 which included the topics of Modern Day Slavery and Domestic Abuse and was well attended by staff working in both adults and children’s services. The Head of Safeguarding Adults attended the event to network with staff and answer safeguarding adult specific questions from attendees.

**Challenges and Achievements**

**Improvements in Practice, Patient Safety and the Delivery of Quality Services**

- SGA forms on RiO were updated with a refreshed form 1- raising a concern, additional form 1a for recording the decision to go to an enquiry under section 42 of the Care Act, specifically for our integrated teams, and a revised form 2 for enquiries. The forms went live from August 2018 with reporting possible from Q3 2018-19.
We developed face-to-face safeguarding adult training at level 3 with versions for mental health staff, community health staff and for managers which was rolled out from April 2019 and early feedback from staff is very good.

We have participated in SAR’s across all three boroughs; providing IMR’s, chronologies and attendance at panel meeting’s and learning events for published SAR’s.

In 2018-19 we worked with our business informatics team to develop the iFox reporting function for CCG’s and SAC data for Local Authorities. We successfully provided year-end figures for activity carried out by our integrated mental health teams to all three borough which by Q4 had all mandatory SAC sections completed.

In 2018-19 we have continued to successfully remain above the NHSE 85% target for Prevent awareness and WRAP. We have fully participated in local Channel Panel meetings in all three boroughs as the mental health representative.

The Head of Safeguarding Adults has continued to have bi-monthly meetings with each of the Borough Heads of Social Care to improve communication and to pick up local operational issues; these have proved a successful way to review local practice around safeguarding.

We have updated the Safeguarding Adults Team pages on the Trust intranet which now includes a section on safeguarding adult reviews (SAR’s) and have updated sections for Modern Day Slavery, domestic abuse and Prevent.

Since February 2019 the Safeguarding Adults Specialist Practitioner has spent 2-3 days per week out in Trust services; meeting staff, attending team meetings, providing adhoc training and drop-in sessions across all three boroughs.

The Trust continues to review all Oxleas acquired pressure ulcers on a monthly basis at the pressure ulcer panel. For these pressure ulcers, a root cause analysis is undertaken, presented to the panel and a decision is made as to whether a safeguarding concern should be raised with the local authority. RCA paperwork has been updated following guidance from the DH and NHSI.

The Trust completed a quarterly programme of auditing the quality of safeguarding adult concerns and enquiries; this was carried out locally in 2018 -19 by the Borough Heads of Social Care. The results were analysed by the corporate SGA team and presented at the quarterly SGA Committee.

The Head of Safeguarding Adults has attended quarterly local borough Patient Safety Group meetings (Quality assurance in Bromley) to feedback on safeguarding adult data and SAR’s.

The Safeguarding Adults Corporate Team have developed “Safeguarding Superstars” where a member of staff is identified each month for exceptional practice in adult safeguarding. They receive a certificate and recognition to their manager, the first winner was in April 2019.

The Head of Safeguarding Adults has been involved with the Trusts Sexual Safety work stream, sitting on the Trust task force and assisting with developing training and information for staff.
Obstacles in Service Delivery and Resource Challenges

- Trust services are delivered across three Local Authorities and one County Council and, whilst all authorities are working to the same safeguarding principles, there are differences in process and systems which has requires the Trust to adapt and vary its own safeguarding procedures to incorporate these. This has meant that it continues to be challenging to develop standardised processes across the organisation.

- Safeguarding Adults data has been difficult to produce for the organisation. The Trust now has a reporting function in iFox but this has not been able to fully report on the numbers of concerns identified and enquiries undertaken in each of the boroughs for work in our integrated teams as easily as we had hoped and still requires a level of manual input to provide the data for the local authorities accurately. Further work is required to improve the RiO forms and in turn iFox reporting, so that our data is as accurate as possible.

- Over the 2018-19 year we have seen a considerable increase in the number of SAR’s being carried out and, as an organisation, working across three boroughs this has increased from one SAR in March 2018 to by the end of 2018-19 a total of six published and a further six in progress, which has had resource implications for the central SGA team in coordinating the IMR’s and attending panel meetings and also staff in the directorates supporting the process. We are also co-ordinating a DHR in each of the three boroughs.

3. Performance Data Set / Audit

SAB Self Assessments and Resulting Action Plans

The Safeguarding Adults at Risk Audit Tool (SARAT) is a self-assessment audit developed by the London Chairs of Safeguarding Adults Boards and NHS England (London). Oxleas completed the SARAT for 2018-19 and so far have presented the results to the Greenwich and Bexley Safeguarding Adults Board’s (SAB). We have a date later in 2019 to present to Bromley SAB. The SARAT identified three areas to be progressed over the year 2019-20.

The action plans for these three areas have been agreed and will now be monitored via the Trust Safeguarding Adults Committee on a 6-monthly basis.

<table>
<thead>
<tr>
<th>Summary of audit findings and identified issues of concern:</th>
<th>The Trust remains complaint in many areas as per the 17/18 audit. Three areas have been identified as requiring more work as outlined below. The Trust has reviewed its provision for safeguarding adults within the organisation and have increased staffing levels from February 2019 to improve capacity for SGA activities across our three boroughs</th>
</tr>
</thead>
<tbody>
<tr>
<td>Actions to be taken Red and Amber areas:</td>
<td></td>
</tr>
<tr>
<td>Area:</td>
<td>Action</td>
</tr>
<tr>
<td>E2 – Your organisation takes steps to ensure that information is obtained from individuals who use your service about what outcomes they wish from the safeguarding process and whether they have received this.</td>
<td>Since the 17/18 audit we have developed and rolled out the new RiO forms including MSP questions and have recently been able to access the data from these in a new informatics format but we are still to analyse the data we have fully and to see how this can be used for improvements in the organisation and learning for staff.</td>
</tr>
<tr>
<td>F2 Your organisation has written information available to</td>
<td>Following review of the available resources from our local authority partners in 2018 we</td>
</tr>
<tr>
<td><strong>adults at risk and their families about safeguarding adults including who to contact if they are concerned about an Adult at Risk.</strong></td>
<td>have realised that there is a difference in what is provided and it may be useful for us to provide our own Trust standard SGA information for staff (leaflets and posters) we provide teams with a trust prevent leaflet currently but only send out SAB resources to teams at this time for SGA. We will develop these resources with our Trust communication team.</td>
</tr>
<tr>
<td>---</td>
<td>---</td>
</tr>
<tr>
<td><strong>G2 – Your organisation is assured that the learning from the SARs has been disseminated to staff</strong></td>
<td>The Trust are working on development of a regular SGA newsletter for all staff to provide more information including details going onto the Trust intranet about SAR’s and the actions and developments following SAR’s from a Trust wide perspective as currently we feel this has just been communicated in each borough and not extended to all staff. This has not been able to progress since 17/18 as we have been waiting for more SAR’s to be published to be able to disseminate a breath of information to staff across all 3 boroughs in the organisation (only Bexley SAR’s published so far).</td>
</tr>
</tbody>
</table>

**Summary / Overview of Dataset and Action Plan**

- The Trust is required to complete a quarterly Safeguarding Adults dashboard for the three Clinical Commissioning Groups (CCGs). The dashboard asks for data in relation to four main areas – Safeguarding Adult Concerns, MCA, training and other process indicators.

- Concerns for the year 2018-19: We reported 310 safeguarding adult concerns raised, a large increase in the figure of 189 concerns raised in 2017-18. We put this down to the improved RiO forms and understanding of the process by staff in the Trust.

- Of the 310 concerns, ten were raised against the organisation and 38 went to enquiry.

- During the year there were two enquiries that were dealt with under the Trust’s disciplinary process involving allegations in relation to members of staff; this is up from 0 cases reported in 2017-18.

- MCA: Within the year we have reported that we applied for 73 Deprivation of Liberty Safeguards (DoLS) authorisations, of which 35 were granted. We have only been able to capture fully the data in relation to reasons for authorisations not being granted more recently since the process has been resourced internally but this is felt to be a combination of outstanding requests, refusals and withdrawals. We have developed an area in RiO to record DoLS activity to enable better reporting in the future.

- Training: We continue to maintain compliance above the 85% target for all our mandatory Safeguarding Adults training throughout the year.

- Other process indicators: This section incorporates data in relation to safer recruitment which was 97% compliant at the end of quarter four.
• The CCG requested that we provide data on the number of MARAC referrals for adults at risk that were made. With changes to our new RIo part 1 form we are now able to collect this information for MARAC referrals that have been made as part of a safeguarding adult concern but only from Q2 2018-19, this totalled six for 2018-19.

• Safer recruitment: The Trust is asked to assure CCGs that all new staff has a DBS check prior to commencing employment. The year-end figure for this was 100%. In addition the Trust is asked to assure compliance with re-checking of DBS status for those staff for which this is required. The year-end figure for this was 100% also.

AUDIT

Other Internal Audits

• In 2018-19 MCA audits have been carried out locally by clinical teams and results shared at the Mental Health Legislation Oversight Group bi-monthly meeting.

Internal Quality Audits

• The Trust was re- audited by KPMG in March 2018 for its Safeguarding Adults and Children’s processes. Safeguarding Adults received a green–amber rating following the re-audit and completed its two actions in 2018-19.
• Developed a new SGA flow chart.
• Safeguarding concerns data quality checks through auditing cases by Heads of Social Care.

The Heads of Social Care were required to submit five cases each quarter from their borough; these audits were analysed centrally and information fed back to the SGA committee. Highlights were-improved raising of concerns for Oxleas service users. Areas for improvement-completing the SGA paperwork on RiO fully and recording MCA.

Following these audit results, all Trust services are now involved in completion of regular MCA audits and there has been increased MCA training for staff put in place. The central SGA team also now review all the paperwork that is raised on RiO through iFox and contact staff directly to ask them to complete the required information for SGA concerns to improve quality of reporting.

Audit plan going forward

Quarterly quality audits will now be completed by the Safeguarding Adults Corporate Team who will review a minimum of 20 randomly selected cases from across the three boroughs and provide analysis and feedback to the SGA Committee and to the Heads of Social Care in each borough who have an operational role in safeguarding to assist with local learning. This will commence from Q1 2019-20 and outcomes for the process reported in our annual report 2019-20.

4. External Partnership Engagement

Oxleas representation at Borough Safeguarding Adults Boards and Subgroups

Whilst we are not statutory members of the three local safeguarding adults boards (SABs) the Trust is committed to working in partnership with the SABs and makes financial contributions towards the budgets of all three.

Bexley

SAB member – Sarah Burchell, Director Bexley Care / Stacy Washington (Oxleas rep)
Local Implementation Network – Dr Sorinmade, Clinical lead for MCA
Performance & Quality - Stacy Washington, Head of Safeguarding Adults & Prevent (as required)
SAR sub group – Stacy Washington, Head of Safeguarding Adults & Prevent

Channel Panel – Stacy Washington, Head of Safeguarding Adults & Prevent

**Bromley**

SAB member – Lorraine Regan, Director Bromley
Training and awareness – Grace John-Baptiste, Lead Social Worker, Bromley
Policies, Procedures & protocols - Grace John-Baptiste, Lead Social Worker, Bromley
Performance & Quality- Stacy Washington, Head of Safeguarding Adults & Prevent
SAR sub group - Stacy Washington, Head of Safeguarding Adults & Prevent

Channel Panel – Stacy Washington, Head of Safeguarding Adults & Prevent

**Greenwich**

SAB – Helen Jones, Director Greenwich
SAR Evaluation Group –Stacy Washington, Head of Safeguarding Adults & Prevent
Performance & Quality- Stacy Washington, Head of Safeguarding Adults & Prevent
Learning & Development – Lorna Lee, Head of Social Care, Greenwich

Channel Panel – Stacy Washington, Head of Safeguarding Adults & Prevent

**Summary of Involvement in Safeguarding Adult Reviews and Domestic Homicide Reviews, including any themes/learning**

**Bexley SAR’s**

The Bexley SAB has now published four SAR’s. The first SAR (1) a gentleman who self-neglected has had a 6-month review of the action plan reviewed by the SAB and by the Trust at the SGA Committee. Key actions are now completed.

The SAB published a further SAR which took the form of an internal learning review in 2018 for a lady who died in 2015 who was known to Oxleas services. Final action plan for this SAR (2) was published end 2018 and our actions were fed back to the SAB in May 2019

The SAB published two further SAR’s in 2019 SAR (3) a female known to Oxleas services was completed by an independent reviewer, a learning event was held in July 2019. The fourth SAR took the form of an internal learning review and was a female who Oxleas had only brief contact with. Both SAR’s have been reviewed at the SGA Committee and actions are being monitored.

In 2018/19 Bexley SAB have commissioned two further SAR’s which have commenced with independent reviewers. Oxleas knew both the male and female involved and have fully engaged in the panel meetings.

**Bromley SAR’s**

The Bromley SAB have published one SAR; the case was of a female who self-neglected, Oxleas had some historic involvement with this lady. We are awaiting a finalised action plan from the SAB.

In 2018/19 they have commissioned one further SAR regarding a care home and neglect of its residents which includes people known to Oxleas service. We have engaged with the process.
Greenwich SAR’s

The Greenwich SAB has published two SAR’s and have one about to be published (awaiting date).

SAR (1) published in 2019. This SAR is running alongside an Independent Mental Health Homicide Review – see below.

SAR(2) and (3) are not cases where Oxleas knew the people involved but will be reviewing the actions and sharing as required.

In 2018/19 Greenwich SAB have commissioned two further SAR’s regarding two females. Both cases Oxleas were involved and we have engaged fully in the process.

Independent Mental Health Homicide Reviews published in 2018/19

The case of Mrs A and Ms B was published in 2019, this case has been presented to the Greenwich SAB and the Trust has an action plan. This is a joint SAR (1) Oxleas had involvement with both victim and perpetrator in this case.

Domestic Homicide Reviews

In 2018/19 Oxleas have been involved with a Domestic Homicide Review (DHR) in each of the three boroughs. In Bexley and Bromley we have knowledge of either the victim or perpetrator from our services. In Greenwich, close family who were on the scene at the time of the offence are known to Oxleas services and so we have been fully engaged in supplying chronologies and IMR’s and attending DHR panels for all three cases.

For full details of the published and ongoing SAR’s please see appendix and SAB websites for reports/Oxleas intranet SAR page.

5. Case studies

Case study (1) caring for service users with dementia

Mrs A was a 90 year old lady living alone in her own property; her only son lived abroad and daughter in-law not nearby. Mrs A had been referred to mental health services as she required support with her memory and cognition, having previously been independent she now needed some support from a private care agency. She objected to the interventions from workers and would not accept an advocate, her son advocated on her behalf.

Mrs A started to self- neglect and lacked insight into her developing dementia. After her morning care visit she would often go out walking in her local area and make various purchases which she could not remember doing and would take various buses and forget which route she was on. There were regular calls to the Police from members of the public and shop staff who had found her when she had lost her way and needed to be returned home. There were a number of Merlin reports over a period, with the Police expressing their concern that this behaviour could not continue and that when they returned her to her home there was very little food in the fridge. A safeguarding Adults Concern was raised and allocated to a Safeguarding Adult Manager in the Trust.

The SAM determined this case met the threshold for a S42 Enquiry under the terms of the Care Act 2014 and an Enquiry Officer, her CPN was allocated. The CPN held a Multi-Disciplinary...
Meeting contributed to by Liaison with family members, discussion with the police, the care agency, a dementia specialist day centre and with Oxleas mental health legislation advisor which led to a safeguarding plan being put in place that included; involving the son who had lasting power of attorney, attempting to get increased support from dementia day care and domiciliary care agency, contact to be made with funding authorities and arranging a joint visit with the CCG for assessment for health funding. Under the terms of Making Safeguarding Personal Mrs A’s CPN sought her views and desired outcomes and what Mrs A said she would like to happen in order to help her to feel safe was to be able to maintain her independence and she still wanted to be able to go out and get her walk each day into town.

It was found that Mrs A lacked capacity regarding the need or agreement for care and treatment and she continued to place herself at risk by leaving her home and getting lost in the local area. She often asked strangers to escort her home and police were frequently contacted due to concerns raised from strangers and shop staff. Mrs A demonstrated no understanding of her declining cognition, her level of functioning, or what support she required in relation to her care and welfare. She could not engage in discussions about her finances or level of support needed and was unable to weigh up or evaluate any of these specific decisions. Therefore these decisions were made in her best interests, with the support of her LPA Son and Daughter in Law.

The Safeguarding Enquiry was concluded and a mental health practice review group, attended by Oxleas staff, the strategic commissioner for the Local Authority and a representative of the CCG unanimously agreed to the need for a care package to ensure that Mrs A received appropriate care to meet her identified needs in accordance with Care Act 2014. Her family were kept informed of decisions throughout.

The Safeguarding Enquiry was substantiated, but the risks could not be completely eliminated as the support put in place was to maximise Mrs A’s ability to enjoy her home life, without depriving her of her liberty. But she now benefitted from a more structured week, which helps to maintain the independence of people living with dementia. Her care was increased to a comprehensive care package to ensure she received appropriate daily personal care and support with adequate nutritional intake. She had 1-1 support so she could access the local community, reducing the risk of her becoming lost and requiring the support from strangers or the police. A care package of 59 hours per week including two days at a specialist day centre was initiated to help reduce the risks and has been successful in keeping her in her own home at this time.

**Case study (2) Making safeguarding personal**

Miss P was a 21-year old woman with a diagnosis of autistic spectrum disorder (Asperger’s syndrome). She was receiving therapy from the local community mental health team and made a significant disclosure of risk of serious harm from her estranged father. There was also a risk to her mother, brother and sister (both under 18) who lived with her.

The father was known to mental health services, had a history of alcohol abuse and carrying weapons and had threatened to harm himself and his family which they took as a literal threat to their lives. Immediate safeguarding actions were taken including Miss P’s mother contacting her father’s mental health team and accessing domestic abuse services. Miss P demonstrated an awareness of the need to lock the front door and call 999 should her father come to the front door and her therapist raised a Safeguarding Adults Concern.

It was determined by the team’s Safeguarding Adults Manager (SAM) that the matter needed to progress to an Enquiry under S42 Care Act 2014. Miss P’s CPN was appointed as the enquiry officer and employed a Making Safeguarding Personal (MSP) approach as defined in the London Multi-Agency Safeguarding Policy & Procedures. Miss P’s wish to deal with the matter herself was respected, whilst ensuring that her ability to do so was maximised. This included carrying out a
Mental Capacity Act 2005 assessment with regard to this specific decision. Miss P demonstrated that she was able to understand, retain, weigh up and communicate this decision.

Miss P also explained that while she needed to be able to explore and express her emotions and concerns in therapy, that she did not expect any particular outcome from doing so. Because the matter was potentially dangerous, the S42 Enquiry went ahead and Miss P’s own safeguarding plan was recorded in order to respect her wishes and promote the Health and Safety of her and her family.

It emerged that the under 18’s were receiving input from local children’s Social Services and that they were also in the process of being referred to CAMHS. Also, Miss P’s mother had taken out an injunction against the father. Miss P wanted three outcomes from the Enquiry:

1. To install a new front door, which the family managed, with a view to keeping themselves safe.
2. To carry out her own safety plan, rather than to rely on external agencies; to get away from her father, should he approach her with intent to harm her and to call the police on her mobile telephone.
3. To continue to benefit from secondary mental health services under CMHT and to enjoy her structured week, which included working, walking the dog and going to the gym.

The S42 Enquiry was recorded as having been substantiated and closed at that point with the appropriate plan in place.

Case study (3) working with partner agencies

Mr B was a middle aged man, well known to mental health services diagnosed with ASD in addition to a severe and enduring psychotic mental disorder. He lived alone and was friends with Mr M, a service user who lived in supported accommodation whom he would see at a local day centre.

Mr M had provided Mr B with some gifts including a mobile phone and Mr B later disclosed that Mr M had told him that he loved him and wants to have sex with him. Mr B explained that he did not want to engage in sexual activity with Mr M and would not disclose his address. It later emerged that Mr M had a history of going to the address of other service users and seeking sex in a similar manner.

Mr B informed his care coordinator who raised the matter as a Safeguarding Adults Concern, as Mr B had care and support needs and was unable to protect himself. Mr B clearly stated that he wanted the abuse to stop and that he wanted help from the police to make sure that this happened in order to feel safer and enjoy going about his business. The community mental health team SAM decided that this met the threshold for an Enquiry under S42 of the Care Act 2014 and allocated the Care coordinator who had the longest working relationship with Mr B as Enquiry officer.

Immediate action was taken to safeguard Mr B which included alerting Mr M’s own care coordinator and for supported accommodation staff to speak to him, advising him that the police would need to be involved if he did not desist from approaching Mr B in this manner.

During the SGA Enquiry Mr M who also had his own disability and level of understanding, approached Mr B again and told him he would ease off contact to satisfy the care coordinators, but would then start again. Mr B wanted the support of police involvement, which was facilitated by his care coordinator.
Under Making Safeguarding Personal (MSP); Mr B said he was very glad for the meeting with the police and he was able to express how he felt. He said he hoped Mr M would be spoken to by police, as he had thus far felt unable to put a stop to the unwanted sexual attention from him.

The police helpfully took away the items Mr M had given Mr B and the matter was logged as a case of harassment. They informed Mr M that if he continued to ignore what he had been asked not to do, or to approach Mr B’s home, then this would be classed as stalking.

The police and care coordinator reassured Mr B after the meeting that none of what had happened was his fault. Prior to and after the meeting they also reassured Mr B that they were there to support him which Mr B clearly found this reassuring, as he presented as relaxed and open throughout the meeting, even though he had a very distant past history of police involvement that had resulted in Mr B having persecutory beliefs that the police were interested in him.

The Enquiry was substantiated and Mr B felt safer as a result of this intervention, because he was heard and supported by the police and mental health services and appropriate boundaries were put in place. In addition, Mr M’s care coordinator was discussing with his team an approved plan, toward formulating a preventative approach to this happening again which would involve some psychoeducation for Mr M.

6. **Future Objectives**

Priorities for the year ahead include:

- Continue to promote the use of the RiO safeguarding forms particularly with community health services and work with the RiO Transformation Team to make forms more user friendly to improve accuracy and avoid human error.

- Remove SGA form 3 from RiO and amend process and flow chart accordingly.

- Improve accuracy of the SGA data for CCG’s and Local Authorities by borough through use of iFox and to do further data analysis to identify trends in the data generated.

- Continue to expand the use of Datix to effectively triangulate information on all safeguarding work in the organisation.

- To evaluate the Trusts face-to-face training workshops (3 versions) and E-learn package for safeguarding adults for Trust staff following feedback.

- To improve working relationship with the Patient Safety Team and the PALS and Complaints Team to ensure that safeguarding adult concerns are identified as part of any investigations.

- To ensure regular and appropriate representation from Oxleas staff at all SABs and subgroups (as required).

- Develop a SAR escalation process due to increasing numbers of SAR’s and DHR’s being seen across the organisation, to co-ordinate the roles for corporate and directorates involvement in process and to embed actions and learning.

- To develop Enquiry Officer training in-house.

- To continue to work and include safeguarding adults in the Trust’s Sexual Safety work stream.
- Continue to roll out “Safeguarding Superstar” using the cases for staff training and on a developed training page on the Trust intranet.

- Closer working with the Safeguarding Children Team – to hold a joint Committee in 2019-20 and linked up training, especially with regard to domestic abuse, Prevent and Modern Slavery and to plan to hold a joint event.

### Safeguarding Adult reviews (SAR) / Domestic Homicide reviews (DHR)

<table>
<thead>
<tr>
<th>Summary of cases Bexley SAB</th>
<th>Update March 2019</th>
</tr>
</thead>
</table>
| **SAR 1**  
MP was a 62 year old man who collapsed and died at Darenth Valley Hospital in 2015. At the time of death he was in a state of severe malnutrition and self-neglect. Case was open to Bexley District Nurses at the time of death | Learning event held in 2016, the report was not published as there are concerns that that the children in the family may be identifiable. Learning from the review cascaded and updates on action plan were presented to the SGA committee in May 2018. |
| **SAR 2 (Internal review)**  
Web 31315  
JW was a 43 year old lady known to the Mental health team who was found in 2015 by a housing officer having died from self-inflicted stab wounds to the chest | Learning event was held in August 2018  
The SAB published the report with an amended action plan on their website. Actions updated to SAB May 2019 |
| **SAR 3**  
Web 59643  
BA was a 42 year old lady known to the Mental health team and social services who died in 2017 following multiple injuries when she went under a train | The SAR was commissioned with an independent reviewer. Final report published on SAB website March 2019 following presentation to SAB board meeting. Learning event on 18th July 2019 |
| **SAR 4 (Internal review)**  
JG was a 45 year old lady who died at home of a suspected drug overdose in Jan 2018 | SAR carried out by SAB member, minimal Oxleas involvement. Final report published on SAB website May 2019, Actions updated to SAB May 2019 |
| **SAR 5**  
Web 66346  
CA was a 19 year old female who died following a ligature whilst an inpatient under Oxleas care in March 2018 | The SAR was commissioned with an independent reviewer commenced May 2019. IMR submitted, first panel meeting taken place, TOR finalised. Awaiting next panel meeting in September 2019 |
| **SAR 6**  
Web69080  
PB was a 55 year old male who died following hanging at his home address, recently discharged from an Oxleas MH team | The SAR was commissioned with an independent reviewer commenced March 2019, panel meeting and TOR completed. Updated IMR submitted to reviewer April 2019, panel meetings held, draft report due September 2019 |
| **SAR 7 (internal review)**  
Web74744  
PS lady who was 8 months pregnant, seen by Oxleas MHLT and midwifery at L&G trust who died from her injuries following the impact of a train | SAB have agreed to carry out an internal learning review of this case with representatives from health involved. Await IMR request and first panel meeting date |
<table>
<thead>
<tr>
<th>SAR 8 – (await confirmation)</th>
<th>Case was presented by police to SAR panel, SI report sent to SAB case will be reviewed at next SAR panel for outcome</th>
</tr>
</thead>
<tbody>
<tr>
<td>Web 74796</td>
<td>YH was a 41 year old lady previously known to PCP who was found with significant multiple self inflicted injuries which required ITU</td>
</tr>
<tr>
<td>DHR 1 –</td>
<td>TOR received. IMR completed. Panel meetings held, await draft report</td>
</tr>
<tr>
<td>SO was a lady previously known to MH services who died by suicide in February 2018</td>
<td></td>
</tr>
<tr>
<td>DHR 2 –</td>
<td>Agreed as a DHR, awaiting confirmation letter and TOR</td>
</tr>
<tr>
<td>Web78073</td>
<td>TT was a lady known to Mental health services who died by suicide in February 2019</td>
</tr>
<tr>
<td>Summary of cases Greenwich SAB</td>
<td>Update January 2019</td>
</tr>
<tr>
<td>SAR 1</td>
<td>Joint SAR and Independent MH Homicide review. Published June 2019, report went to Greenwich SAB in March. Actions being monitored by Trust Board</td>
</tr>
<tr>
<td>Web39875</td>
<td>SAR 1 was published April 2019, 1 action for JET team</td>
</tr>
<tr>
<td>A review into the care and treatment of a female PE who was killed by her daughter in 2016 who were both known to Oxleas services</td>
<td></td>
</tr>
<tr>
<td>SAR 2</td>
<td>SAR 2 was published April 2019, 1 action for JET team</td>
</tr>
<tr>
<td>JF Inappropriate use of hoist in care home</td>
<td></td>
</tr>
<tr>
<td>SAR 3</td>
<td>This SAR has been commissioned by RBG but Oxleas do not have any involvement, awaiting date to publish report presented to SAB July 2019</td>
</tr>
<tr>
<td>NW Died from fall in care home</td>
<td></td>
</tr>
<tr>
<td>SAR 4</td>
<td>RBG have commissioned a SAR, awaiting TOR and first panel meeting in August 2019, Chronology submitted May 2019.</td>
</tr>
<tr>
<td>Web63654</td>
<td>RBG have commissioned a SAR, awaiting finalised TOR. Oxleas not on panel, chronology submitted May 2019.</td>
</tr>
<tr>
<td>KM was a 67 year old lady who died in QE in December 2017 from sepsis. She was known to the mental health team as an outpatient for organic psychosis following a brain tumour.</td>
<td></td>
</tr>
<tr>
<td>SAR 5</td>
<td>RBG have commissioned a SAR, awaiting finalised TOR. Oxleas not on panel, chronology submitted May 2019.</td>
</tr>
<tr>
<td>LD was a 82 year old lady who died choking in a care home in January 2017</td>
<td></td>
</tr>
<tr>
<td>SAR 6</td>
<td>This SAR is to be commissioned by RBG, Oxleas had no recent involvement in this case only historic await TOR to see involvement required</td>
</tr>
<tr>
<td>GM was a 38 year old who died of sepsis, UTI and infected leg ulcers, diagnosed with spina bifida as a child and hydrocephalus</td>
<td></td>
</tr>
<tr>
<td>SAR 7</td>
<td>This will be a Joint SAR and Independent MH Homicide review, to be arranged by NHSE with RBG. Awaiting TOR and first panel meeting date</td>
</tr>
<tr>
<td>Web69375</td>
<td>GS was a 56 year old lady who was stabbed to death by another resident at her accommodation both were known to Oxleas MH services</td>
</tr>
<tr>
<td>DHR 1</td>
<td>First panel meeting held limited information on victim and perpetrator available, chronology</td>
</tr>
<tr>
<td>SM was a lady killed by her husband in November</td>
<td></td>
</tr>
</tbody>
</table>
2018 at home witnessed by their daughter and grandson who were known to Oxleas services provided for Trust involvement with daughter/grandson. Next meeting due November when case due in court.

<table>
<thead>
<tr>
<th>Summary of cases Bromley SAB</th>
<th>Update January 2019</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>SAR 1</strong></td>
<td></td>
</tr>
<tr>
<td>Web58649</td>
<td></td>
</tr>
<tr>
<td>KR was a 28 year old lady known to social services, community health services and in the past by Oxleas. She had a long history of non-concordance with her diabetic medication and self-neglect and died in 2017 from complications of type 1 diabetes.</td>
<td>Bromley SAB commissioned an independent reviewer. Final report published on SAB website May 2019. Actions meeting held July 2019, awaiting final action plan from SAB</td>
</tr>
</tbody>
</table>

| **SAR 2**                     |                     |
| IJ/ Rosecroft care home. IJ was a 90 year old lady who died from pneumonia but there had been concern with neglect in the care home for IJ and other residents | Bromley SAB has commissioned an independent reviewer. TOR received, first panel meeting June 2019. SAB to provide details of all residents of care home for Oxleas to review involvement |

| **DHR 1**                     |                     |
| Web71693                      |                     |
| CL – mother of a 36 year old man BL previously know to MH services, was found dead, killed by her son at home in August 2018 | Panel meetings commenced in 2019, IMR completed, awaiting draft report |
7. Appendix A

SAFEGUARDING ADULTS
RAISING A CONCERN

Is the adult at risk an Oxleas service user?

NO

Contact the Local Authority to report your concerns.
Bexley: 020 8303 7777
Bromley: 020 8461 7777
Greenwich: 020 8921 2304

YES

Confirm the nature of the allegation with the service user, especially if information is received from a third party

- Manage immediate risk & safety issues
- Record in Datix and RiO progress notes
- Discuss the case with your manager/senior colleague

Is this a Safeguarding Adult Concern?

YES

Complete SGA Part 1 form in RiO

NO

- Record as no further action in RiO/ datix
- Review case in supervision

Does your team have a Safeguarding Adults Manager (SAM)?

YES

Concern MEETS the S42 threshold

Record decision in form 1a SAM to allocate Enquiry Officer (EO)

EO to complete enquiry and SGA Part 2 form

SAM to complete SGA Part 3 in RiO to outcome enquiry

NO

Concern does NOT meet S42 threshold

Record as no further action in RiO, complete form 1a

Did the Local Authority undertake an enquiry?

NO

YES

Email a PDF copy of the SGA Part 1 RiO form to the Local Authority
Record in progress notes

Record as no further action in RiO (form1a)

Record in RiO (form 1a) and outcomes in progress notes
REPORTING SAFEGUARDING ADULT CONCERNS AT THE BRACTON

Assess potential risk to adult
DELAY COULD BE HARMFUL

Physical Injury
Serious or Life Threatening
CALL 999 AND INFORM
DUTY DOCTOR

Physical Injury
No Immediate Danger

Neglect, Financial
Abuse, Emotional
Abuse, Sexual Abuse

SEEK ADVICE

ENSURE patient is safe and supported
LISTEN to concerns from patient and how they wish them to be acted on
CLARIFY facts, do not discuss with alleged perpetrator, and secure evidence that may be needed for investigation
EXPLAIN you will inform Ward Manager and Ward Social Worker to safeguard patient and feedback plan to them

Report to police if a suspected crime committed

Consider capacity issues at all stages

Inform line manager if concerning a staff member

INFORM Ward Manager, Ward Social Worker and Responsible Clinician
RECORD on Rio
REPORT as per Oxleas Incident Management Policy and Procedure

Refer to Bracton Safeguarding Adults Policy and Procedures on G-drive

MEETS CRITERIA FOR ALERT

Complete and email Kent Safeguarding Alert form by secure email. Ensure it is received and agree immediate safeguarding plan. Inform patient and record on Rio.

Ward Social Worker or Ward Manager to liaise with Kent Safeguarding Team and follow borough procedure. Review the Safeguarding Plan.

DOES NOT MEET CRITERIA FOR ALERT

Inform Patient and Record Decision

USEFUL CONTACTS
Ward Manager/Ward Social Worker
Senior Social Worker Alison Barnes
Oxleas Safeguarding Lead Stacy Washington: 01322 625009
Safeguarding Children Annual Report

April 2018 – March 2019

Author: Ida Bradford Head of Safeguarding Children

Executive Safeguarding Lead: Jane Wells Director of Nursing
### Contents:

<table>
<thead>
<tr>
<th>Section</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Introduction</td>
<td>3</td>
</tr>
<tr>
<td>2. Progress against Safeguarding Children Strategy</td>
<td>4</td>
</tr>
<tr>
<td>3. Development of knowledge and skills</td>
<td>12</td>
</tr>
<tr>
<td>4. Mainstreaming safeguarding children</td>
<td>16</td>
</tr>
<tr>
<td>5. Learning from experience</td>
<td>18</td>
</tr>
<tr>
<td>6. Engagement with Service Users</td>
<td>21</td>
</tr>
<tr>
<td>7. Priorities for the year ahead</td>
<td>25</td>
</tr>
<tr>
<td>8. Conclusion</td>
<td>26</td>
</tr>
</tbody>
</table>
1.0 Introduction

This report outlines progress against the aims of the Oxleas Safeguarding Children Strategy for the period of April 2018 – March 2019 and describes how we fulfill our responsibilities in relation to Section 11 of the Children Act 2004.

- Definition of safeguarding

Safeguarding and promoting the welfare of children consist of a variety of provisions that require an organisation-wide approach. It is defined as:

  o Protecting children from maltreatment.
  o Preventing impairment of children’s health or development.
  o Ensuring that children grow up in circumstances consistent with the provision of safe and effective care.
  o Taking action to enable all children to have the best outcomes.

- Oxleas Duties

Section 11 of the Children Act 2004, places a duty upon Oxleas NHS Foundation Trust to ensure its functions are discharged with regard to the need to safeguard and promote the welfare of children. We do this by:

  o Having a clear line of accountability and governance within and across the trust and provision of services designed to safeguarding and promote the welfare of children
  o Having clear priorities for safeguarding and promoting the welfare of children underpinned by a key policy and relevant procedures that are founded in legislation, national and local guidance.
  o Having procedures for dealing with allegations of abuse against members or staff, safer recruitment processes and whistleblowing policy.

- Changes in local safeguarding children arrangements

The Children and Social Care Act 2017 makes changes to the arrangements to former Local child safeguarding boards shifting the overall responsibility to three safeguarding partners (the local authority, a clinical commissioning group and the chief officer of police). The Act further stipulates changes to the serious case review and child death review processes. Guiding frameworks for the new ways of working are specified in the Working Together to Safeguard Children document (HM Government, 2018) focusing on core legal requirements of individuals, organisations and agencies, with effect from June-September 2019.
• **Oxleas Safeguarding Children Strategy**

Oxleas vision is to ensure safeguarding and promoting the welfare of children is embedded across every directorate and in every aspect of work. Underpinned by the Think Family approach, children and young people should be considered in all interactions with their carers and adult service users. The welfare of children must be of a paramount consideration.

The strategy was reviewed and updated in April 2017 and comprises 7 areas:

- Effective safeguarding children frameworks
- Developing knowledge and skills
- Mainstreaming safeguarding children
- Learning from experience
- Strengthening partnership working
- Promoting early help for children and families
- Engaging with service users

**Safeguarding Children Priorities for the Year 2018/2019**

- To promote use of the new Safeguarding RiO forms in children’s and adult services.
- To report an improved safeguarding children data set.
- To raise awareness of and increase clinicians confidence in respect of recognising and responding to neglect CSE and FGM.
- To raise awareness of the particular vulnerabilities of children under 1 year of age, safer sleep and abusive head trauma.
- To embed a ‘Think Family’ approach in adult focused services so that children in the adult client network are identified and the needs of the child are always considered.
- To promote a culture of learning, to set up joint learning events for adult and children’s services.

• **Summary of achievements over the past year against the priorities**

**RIO SAFEGUARDING FORM**

RIO safeguarding forms, accompanied by a set of guidance available on the Ox, were introduced to children’s services in April 2017 and to adult focused staff in October 2017. Past serious incidents relating to Adult mental health services showed inadequate assessment and documentation of children in the adult client network. In June 2018, we carried out an audit exploring documentation of Children in adult network within inpatient adult mental health services. The audit showed that 35% of clients audited had never been asked if there were children in their network and for the 65% who were asked, only 24% cases evidenced correct
RIO documentation. Emerging from the findings above, concerns for potential safeguarding children actions being delayed or missed were identified and logged via the Safeguarding children risk register. As a result the risk has been monitored by the Safeguarding children committee with a robust mitigation plan.

SAFEGUARDING CHILDREN ANNUAL EVENT
A trust-wide learning event was held on 30th November 2018 to share the learning from serious incidents and serious case reviews with clinicians from both Children and young people services and Adult mental health. The focus of the event was on:

- Abusive head trauma
- The role of Adult mental health staff in safeguarding children
- Learning lessons from Serious Case Review Child V

In addition, CAMHS held a one day event for all staff which included training on vulnerable adolescents and county lines linked to findings from the 2018 Joint targeted area inspection.

‘THINK FAMILY’ -
Throughout the period, our Adult mental health safeguarding children lead continued to offer regular ‘drop ins’ for in patient and community setting these offer practitioners an opportunity for case discussion and/or for ad hoc safeguarding children updates.

The safeguarding children intranet page was refreshed and updated to provide staff with clear information and resources to support their practice. Our staff have reported that they find the intranet site easy to use and it supports their understanding of key safeguarding issues.

LEARNING LESSONS
In response to lessons learnt from child deaths under one year of age, our Consultant paediatrician, Named doctor, the Designated nurse and the Lullaby trust worked collaboratively to deliver a workshop on Safer Sleeping and Abusive Head Trauma. Children’s specialist services staff now offer parents to view the sleeping arrangements for any children under 1 year to whom they provide a service. Similarly, the Health visiting service have increased their surveillance of sleeping arrangements and continue to explore the most effective ways to provide evidence based advice to parents.

On the back of the Child Z Serious case review (Greenwich), we developed and delivered workshops to all 0-19 and specialist CYP team to ensure practitioners are confident in using the Greenwich neglect toolkit and utilise it when referring to children’s social care.
POLICY UPDATES -
Our Domestic Violence and Abuse policy was updated in October 2018 to include changes arising from the Data Protection Act 2018 and General Data Protection Regulation, The Care Act (2014) in order to link with Safeguarding adults and the Serious Crime Act (2015) in recognition of controlling and coercive behavior in a family or intimate relationship. The policy includes further guidance for employees and provides specific practice examples of asking all clients about domestic violence and abuse where it is safe to do so.

Oxleas Safeguarding children policy was updated to reflect key changes within the Working Together guidance (2018) in preparation for wider systems reform arising from the Children and Social Care Act (2017).

MULTI-AGENCY WORKING
The Trust continues to work in close partnership with our statutory partners in Greenwich, Bromley and Bexley. We assure Oxleas representation at the local safeguarding board meetings and subgroups and participate pro-actively in multi-agency audits, training, learning lessons and serious case reviews (please see page 10).

2.0 Progress against Safeguarding Children Strategy / change

• Effective Safeguarding Children Framework

’Safeguarding children roles, responsibilities and structures provide a framework which supports and develops best practice. We aim to ensure effective working by having a robust safeguarding children governance arrangements supported by the safeguarding children committee, safeguarding children team, management leads and champions and that access to advice and reporting mechanisms are clear to staff’.
Board level accountability for safeguarding (children and adults) is held by the Director of Nursing who is the chair of Oxleas Safeguarding children committee. The Safeguarding children committee membership includes directorate Leads for safeguarding children, Local safeguarding children board representatives and designated professionals, as well as a representative from University of Greenwich.

### Safeguarding Children Governance arrangements

**Board of Directors (Bi-monthly)**
Board level oversight of Safeguarding Children will be maintained via sub-committee meetings and annual reports.

**Performance and Quality Assurance Committee (Monthly)**
The focus of this committee will be to review performance in key quality indicators for patient safety, patient experience and compliance with standards including infection control and NICE guidelines. This will include reports from the Safeguarding Children Executive Lead on quality assurance matters.

**Trust Executive (Monthly)**
Every two months, the Safeguarding Children Executive lead report to the Executive on key issues/risks and key performance indicators.

**Safeguarding Children Committee (Quarterly)**
Chair: Safeguarding Executive Lead
• **Safeguarding children team**

The Safeguarding children team is supported by directorate leads and by a network of team based Safeguarding children champions. Safeguarding children is an agenda item on each of the Borough directorate Patient safety groups and a member of the Safeguarding children team attends quarterly to ensure there is a clear understanding of the priorities and safeguarding children arrangements.

During 2018/2019 the Safeguarding team experienced a high staff turnover including a loss of the Head of safeguarding children. Despite staff vacancies, the team maintained consistent delivery of the safeguarding strategy and achieved excellent compliance with training and supervision requirements.

• **Safeguarding Children Champions**

The networks of Safeguarding Children Champions act as an additional safeguarding resource to Oxleas workforce. Children’s safeguarding champions are supported in their role by Borough based meetings which are held twice a year and the annual trust-wide Safeguarding Children Champion Event held in November 2018.

**Borough Based Champions**

<table>
<thead>
<tr>
<th></th>
<th>Greenwich</th>
<th>Bexley</th>
<th>Bromley</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>2016/2017</td>
<td>63</td>
<td>39</td>
<td>30</td>
<td>155</td>
</tr>
<tr>
<td>2017/2018</td>
<td>66</td>
<td>49</td>
<td>27</td>
<td>142</td>
</tr>
<tr>
<td>2018/2019</td>
<td>87</td>
<td>51</td>
<td>29</td>
<td>167</td>
</tr>
</tbody>
</table>
Oxleas Representation at local Safeguarding children boards and subgroups

The Trust works in partnership with, and is fully engaged with, the three local Safeguarding Children’s Boards (LSCBs) of whom we are statutory partners.

**Bromley**
- Bromley Safeguarding Children Board Member: Director of Nursing, Jane Wells
- Quality Assurance and Performance Management (QAPM): Head of Safeguarding children
- Bromley Health Forum: Head of Safeguarding, Safeguarding specialist advisor
- Vulnerable Adolescent Multi-agency Meeting – Bromley CAMHS consultant nurse

**Bexley**
- Bexley Partnership Board Member: Service Director Bexley Care, Tom Brown (now Sarah Burchell)
- Quality and Effectiveness Board (meets 8 times a year): Head of Safeguarding children
- Bexley Learning Hub: Named nurse for safeguarding children, AMH Specialist advisor
- CSE MASE: Named nurse for safeguarding children
- Learning from Serious incidents Subgroup: Head of Safeguarding children
- Child Death Overview Panel CDOP: Bexley Consultant Community Paediatrician

**Greenwich**
- Greenwich Safeguarding Children Board Member: Director of CY&P, Stephen Whitmore
- Multi-Agency Challenge Group MAC: Head of Safeguarding children
- GSCB Audit Sub Group: Named Nurse for Safeguarding Children
- Serious Incident Sub Group: Head of Safeguarding children
- Child Death Overview Panel CDOP: Greenwich Community Consultant Paediatrician
- GSCB Learning and Development : Named nurse for safeguarding children
- Neglect Sub Group: Safeguarding Children Lead AMH
- Communications and Engagement: Greenwich Safeguarding adviser
- Greenwich Health Forum: Named nurse Greenwich, 0-19 Service Lead
- Violence Against Women and Girls Sub Group: Named nurse for safeguarding children
- Greenwich risk adolescence safeguarding and prevention panel: Safeguarding adviser.

- Oxleas Representation at MARAC (Multi Agency Risk Assessment Conferences)

Oxleas is engaged with MARAC meetings in each Borough. MARAC is a model of multi-agency intervention in high risk domestic abuse cases which involves risk assessment and safety planning.
• **Multi –Agency Safeguarding Hubs (MASH)**

Oxleas provides two full time MASH Health professionals in the Greenwich MASH and one full time Health professional in Bexley MASH. We are part of both operational and strategic development of the MASH service and work closely with our local authority partners towards making high quality decisions about safety of our children and families.

• **Safer Recruitment and Human Resources Processes**

Oxleas has a designated senior Human Resource professional to ensure arrangements are in place with regards to the management of allegations against staff, including reporting responsibility to the local authority designated officer (previously known as the LADO). Raising a concern flowchart is available to all staff on the intranet.
3.0 Development of Knowledge and Skills

‘Children and families need safe, confident practitioners. Staff will demonstrate the values and competences required to effectively safeguard and promote the welfare of children. Compliance with mandatory safeguarding children training will be monitored. We will ensure that all learning provision enables practitioners to enhance their skills and competence (beyond updating) supports organisational learning from experience and remains reflective of the current context and evidence’.

- **Safeguarding Children Learning** (written in collaboration with Oli Setikovska, Head of Learning and Development)

The trust continues to demonstrate excellent compliance with core updating expectations, aligned to the Intercollegiate Document. The following mandatory updating compliance levels were evidenced across the trust as a whole at the end of March 2019:

<table>
<thead>
<tr>
<th>Updating Level / Requirement</th>
<th>Compliance Rate</th>
</tr>
</thead>
<tbody>
<tr>
<td>Level 1</td>
<td>97.96%</td>
</tr>
<tr>
<td>Level 2</td>
<td>96.37%</td>
</tr>
<tr>
<td>Level 3 Core</td>
<td>87.65%</td>
</tr>
<tr>
<td>Level 3 Specialist</td>
<td>91.04%</td>
</tr>
<tr>
<td>Prevent Awareness (levels 1 &amp; 2)</td>
<td>98.54%</td>
</tr>
<tr>
<td>Prevent Practice (WRAP)</td>
<td>95.46%</td>
</tr>
<tr>
<td>Safer Recruitment &amp; Selection</td>
<td>97.34%</td>
</tr>
<tr>
<td><strong>Indicative total</strong></td>
<td><strong>95.25%</strong></td>
</tr>
</tbody>
</table>

To support interpretation, in the light of audience size differences, we note that taken together, 95.25% of all mandatory safeguarding children learning requirements were met across the trust as a whole at end 2018/19. This represents a 2 percentage point improvement on the previous year end position. It is worth adding that a positive assurance position was sustained throughout the year.

To focus purely on compliance with minimum updating expectations as defined by our Mandatory Training Policy would be to overlook the host of learning and updating which takes place over and above minimum standards.

We have a range of learning and updating mechanisms in place to support development of staff competence in relation to safeguarding children. To recognise the wealth of developmental activity which our workforce engages in, the following sections set out the full range of safeguarding learning which took place between April 2018 and March 2019.
• **E-learning**

The numbers of staff who completed e-learning contributing towards the development of safeguarding children competence are summarised below. To support interpretation, we note that a number of staff have completed more than one e-learning course. Also, to avoid any ‘double-counting’, where Prevent Awareness is incorporated in other provision, it has not been listed separately below. What follows thus arguably under-represents safeguarding learning. The total is presented purely for illustrative purposes, to facilitate rough comparison with the previous year’s activity.

<table>
<thead>
<tr>
<th>E-learning Course</th>
<th>Completions</th>
</tr>
</thead>
<tbody>
<tr>
<td>Level 1 Awareness</td>
<td>387</td>
</tr>
<tr>
<td>Level 2 Introduction</td>
<td>930</td>
</tr>
<tr>
<td>Level 3 Update</td>
<td>284</td>
</tr>
<tr>
<td>Child Sexual Exploitation</td>
<td>87</td>
</tr>
<tr>
<td>Domestic Abuse</td>
<td>409</td>
</tr>
<tr>
<td>Female Genital Mutilation</td>
<td>176</td>
</tr>
<tr>
<td>Forced Marriage</td>
<td>16</td>
</tr>
<tr>
<td>Prevent (WRAP equivalent)</td>
<td>557</td>
</tr>
<tr>
<td>Safer Recruitment &amp; Selection</td>
<td>141</td>
</tr>
<tr>
<td><strong>Indicative total</strong> (as some staff have completed more than one piece of relevant e-learning)</td>
<td><strong>2,987</strong></td>
</tr>
</tbody>
</table>

A total of 2,987 e-learning completions were recorded in 2018/19 (compared with 2,067 in the previous year). The increase in e-learning uptake is largely attributable to the introduction of national e-learning to support updating at level 3, as well as national Prevent WRAP e-learning, launched towards the end of the previous financial year. Other activity has remained broadly comparable with previous trends, despite recent introduction of a new bespoke Domestic Abuse package which can also be used to support overall updating.

• **Face to face learning**

In terms of face to face learning, the trust continues to offer a number of learning options tailored to address the needs of our diverse workforce. Uptake rates for these programmes between April 2018 and March 2019 are summarised below, alongside uptake of external safeguarding learning. As with e-learning, it should be noted that some staff members have accessed more than one course in the year covered by this report, thus the totals shown should be treated merely as illustrative of the total volume of face to face learning activity.

<table>
<thead>
<tr>
<th>Face to Face Course</th>
<th>Completions</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Internal learning</strong></td>
<td></td>
</tr>
<tr>
<td>Level 3 Introduction (various courses)</td>
<td>95</td>
</tr>
</tbody>
</table>
We recorded 863 face to face learning attendances in 2018/19 (compared with 1,641 in the previous financial year). Whilst participation levels are lower than those seen the previous year, they are broadly as expected taking into account workforce updating timescales and conclusion of Prevent learning implementation in the previous year.

**Overall Participation Trends**

Taken together, we recorded 3,850 safeguarding children learning completions in the financial year 2018/19, summarised below:

<table>
<thead>
<tr>
<th>Learning Type</th>
<th>Completions</th>
</tr>
</thead>
<tbody>
<tr>
<td>E-learning</td>
<td>2,987</td>
</tr>
<tr>
<td>Face to Face</td>
<td>863</td>
</tr>
<tr>
<td><strong>Indicative total</strong> (as some staff have accessed more than one safeguarding children course)</td>
<td><strong>3,850</strong></td>
</tr>
</tbody>
</table>

2,624 members of staff completed at least one piece of safeguarding children learning, be this through face to face course attendance or e-learning. Of these, 840 (32%) completed more than 1 piece of relevant learning in-year. The breakdown, demonstrating continued strong engagement with safeguarding updating, is presented below:

<table>
<thead>
<tr>
<th>Number of In-Year Completions</th>
<th>Staff Number</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>1,784</td>
</tr>
<tr>
<td>2</td>
<td>582</td>
</tr>
<tr>
<td>3</td>
<td>181</td>
</tr>
<tr>
<td>4 or more</td>
<td>77</td>
</tr>
<tr>
<td><strong>Indicative total</strong></td>
<td><strong>2,624</strong></td>
</tr>
</tbody>
</table>

**Evaluation and Impact**

We continue to receive extremely positive feedback about our internal safeguarding children learning provision. Sample narrative comments, illustrating perceived impact for learners, are included below.
The delivery team reflect on all feedback received both immediately post session and more holistically at our regular team meetings. We make minor content and/or adjustments in a responsive manner as standard, reflecting live feedback, to ensure our programmes continue to reflect current participant needs or concerns.

We implemented a more rigorous approach to follow-up impact evaluation in 2018/19. Data gathered to date in respect of Safeguarding Children learning is limited at present but extremely encouraging. All those who responded to our surveys in relation to courses delivered in the second half of 2018/19 rated the learning as either ‘excellent’ or ‘good’. They all said they have used their new knowledge / skills in practice. Only one reported experiencing ‘some’ barriers to learning application. Feedback in respect of Prevent training was broadly equivalent, though with more respondents saying they have yet to identify an opportunity to put their learning into practice.

- Future Provision Plans

We began updating our face to face learning provision to reflect the 4th edition of Safeguarding Children Roles & Competences Intercollegiate guidance published in the last quarter. This work will continue into 2019/20.

No substantial delivery revision requirements have been identified. We will of course continue to update the detail of our face to face learning content in line with recent lessons learnt and to appropriately reference current topical issues in safeguarding. We will also continue to monitor the national e-learning offering and take advantage of any newly released content, to ensure we continue to offer as broad a range of updating and specific focus learning for our workforce as possible.
### 4.0 Mainstreaming Safeguarding Children

‘Safeguarding and promoting the welfare of children will be reflected in all areas of the Trust’s activity and business. Managers and staff across the organisation have a key role to play in promoting practice which keeps the child in focus and listens to the voice of the child. Performance is monitored and reported through governance arrangements, up to the Board.’

#### • Referral Activity

Referral activity 2018/2019 and previous activity

<table>
<thead>
<tr>
<th>BOROUGH</th>
<th>AMH</th>
<th>CAMHS</th>
<th>Universal/ Specialist Services</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>16/17</td>
<td>17/18</td>
<td>18/19</td>
<td>16/17</td>
</tr>
<tr>
<td>BEXLEY</td>
<td>17</td>
<td>11</td>
<td>12</td>
<td>9</td>
</tr>
<tr>
<td>BROMLEY</td>
<td>33</td>
<td>31</td>
<td>39</td>
<td>19</td>
</tr>
<tr>
<td>GREENWICH</td>
<td>12</td>
<td>26</td>
<td>22</td>
<td>26</td>
</tr>
</tbody>
</table>

The number of children’s social care referrals is comparable to 2016/2017. In Bexley the decrease in referrals in children’s universal services can be accounted for by the service transferring to Bromley Health Care in May 2017.

The Safeguarding children team has a robust system for assuring referral standards are followed, although we remain aware of shortcomings of our current monitoring system through a manual collection of children’s social care referral data. The Safeguarding children committee is sighted on the low number of referrals in certain areas and this has been highlighted to operational managers. Going forward we aim to align safeguarding children and adults’ referral processes on RIO, which will enable more accurate electronic collection of required data through the IFox platform.
As per our priorities, the safeguarding children datasets were reviewed and improved and remain a standing item on the Safeguarding Children Committee agenda.

- **Safeguarding Children Supervision**

  In Oxleas, accessing appropriate safeguarding children supervision is a mandatory and professional requirement for all practitioners working with children and young people.

  Health visitors are required to receive safeguarding supervision every three months and School nurses every school term. Compliance with supervision requirements remains excellent, achieving 96% for health visitors and school nurses in Greenwich and 92% for health visitors in Bromley (although 100% staff who were due for supervision did receive it, the figures are lower due to maternity and long term sickness within the teams).

  CAMHS Safeguarding Supervision is incorporated into clinical supervision. Cases where a child is subject to a Child Protection Plan must be discussed every 6 weeks. The data is collected manually every month. An exception report is provided quarterly where the compliance rate has fallen below 100%.

  The Safeguarding Team provides group supervision to practitioners in Children’s therapy services and Looked After children team. We are pleased to report that 100% compliance has been achieved for children’s therapy in Bexley, 80% compliance for audiology service (due to maternity leave) and 100% for Greenwich.
5.0 Learning from Experience

‘We will examine the quality and impact of practice using quantitative, qualitative and outcome measures. We will systematically learn through experience (including Serious Case Reviews, incidents and complaints) and ensure that services are developed and monitored which promote children’s welfare.’

| Serious Case Reviews |
|----------------------|-----------------|
| **Greenwich Serious Case Review** | ‘Child U’ |
| | Published in January 2019. |
| **Background** | Death of an 8 week old baby due to series injuries whilst in the care of the parents. |
| **Datix WEB 47773** | Case did not meet threshold for Level 4 Service: Health visiting |

**Key learning**

| The use of interpreters | Professional opinion was divided over whether the mother understood sufficient English, and at times Child U’s father was relied upon to interpret. Mother was already reliant upon him for accommodation and support due to her immigration status, and using him to interpret risked denying her a voice. |
| Professional curiosity about fathers | Professionals were not sufficiently curious about the father of the baby. Despite him being present at appointments most of the focus of assessments was on the mother. |
| Impact of Immunisations | Communicating to parents that children may be more challenging to care for following immunisations, and advice being made available about the fragility of babies, coping with crying and parental stress. |
| Conclusion | The serious case review in relation to Child U found that there were no indications that he was more vulnerable than any other infant in a family facing homelessness, and that this tragic incident could not have been prevented by the professionals working with the family. |
**Greenwich Serious Case Review**

<table>
<thead>
<tr>
<th>Case</th>
<th>‘Child V’</th>
<th>Serious Case Review published in December 2018.</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Background</strong></td>
<td>Death of a 3 month old baby due to non-accidental head injury and rib fractures.</td>
<td></td>
</tr>
<tr>
<td><strong>Datix 49610</strong></td>
<td>Level 4 incident</td>
<td></td>
</tr>
<tr>
<td>Service:</td>
<td>Health visiting and Adult Mental Health</td>
<td></td>
</tr>
</tbody>
</table>

**Key learning**

<table>
<thead>
<tr>
<th>Use of systems</th>
<th>The importance of systems that do not rely on the presence of individuals.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Better use of early help</td>
<td>Families are much more likely to thrive and have a positive outcome for their children if their difficulties are recognised at an early stage and they receive help (this includes expectant mothers). No use was made of mechanisms for offering early help and although individual agencies offered support to mother, this was largely adult focused and not co-ordinated.</td>
</tr>
<tr>
<td>Recognition and response to non-engagement in antenatal care.</td>
<td>The mother’s failure to engage in any antenatal care was not recognised by many agencies and the safety net of universal services as a way of catching vulnerable children before they slip through the net did not work in this case.</td>
</tr>
<tr>
<td>Over-reliance of self-reporting and disguised compliance</td>
<td>The mother repeatedly told professionals that she had accessed or would access services without this being triangulated with other professionals or checking records. Her version of events was accepted without challenge and it is important that professionals recognise a reliance on parental self-reporting and be open to the possibility of disguised compliance.</td>
</tr>
<tr>
<td>Professional curiosity about fathers</td>
<td>Professionals were not sufficiently curious about the father of the baby. Enquiries were made and responded to with vague responses of his promised involvement but these statements were not explored further.</td>
</tr>
</tbody>
</table>
### Background
Young person X took his life by falling from the 9th floor of a building.

### Datix Web 56246
- Level 5 incident
- Services: CAMHS and LAC

### Key Learning

<table>
<thead>
<tr>
<th>Key Learning</th>
<th>Details</th>
</tr>
</thead>
<tbody>
<tr>
<td>The impact of exposure to domestic violence</td>
<td>Practitioners need to be alert to the longer term trauma that young people may suffer when they have witnessed domestic violence in their families. In this case Young Person X’s experiences undermined his sense of self-worth and rendered him insufficiently resilient to cope with the demands of personal relationships.</td>
</tr>
<tr>
<td>Challenges of working with adolescents entering the care system at a late stage</td>
<td>Young Person X’s parents retained parental responsibility for him and he was of an age where he wanted to make his own choices. Practitioners, in partnership with Young Person X and his family, needed to work better together to set clear expectations about contact and where he should be living.</td>
</tr>
<tr>
<td>Adolescent self-harm and suicidal thoughts</td>
<td>Psychiatric services provided to Young Person X responded well to his symptoms but did not, in the time available, facilitate his ability to enable him to cope better with his emotional difficulties once back in the community. However, while the risk of self-harm was high for Young Person X, the fatal event itself was not judged to be preventable or predictable.</td>
</tr>
<tr>
<td>Safety Plans</td>
<td>When working with vulnerable adolescents, the importance of clear safety plans that are informed by and owned by multi-agency partners and families. These plans must be reviewed by managers in the individual agencies.</td>
</tr>
<tr>
<td>Discharge planning</td>
<td>When children move from psychiatric in-patient settings to the community, there should always be a multi-agency discharge planning meeting, including schools, and for children in care a Looked After Review.</td>
</tr>
<tr>
<td>Safeguarding adolescents</td>
<td>It is important that practitioners explore and understand significant relationships for adolescents outside the immediate family and the impact these may have on risk.</td>
</tr>
<tr>
<td>Education is a key protective factor</td>
<td>Young Person X was academically able and school provided a high level of support. As a result of his challenging behaviour in school, linked to his worsening emotional resilience, Young Person X was appropriately excluded. Agencies did not have a shared understanding of the impact of this on his wellbeing.</td>
</tr>
<tr>
<td><strong>Bexley Serious Case Review</strong></td>
<td>‘Baby John’</td>
</tr>
<tr>
<td>-----------------------------</td>
<td>-------------</td>
</tr>
<tr>
<td></td>
<td>Published in September 2018</td>
</tr>
</tbody>
</table>

**Background**
Baby John suffered a fractured skull in March 2017 when he was 13 months old. Baby John made a full recovery and continued to live with his parents.

<table>
<thead>
<tr>
<th><strong>Datix Web 56049</strong></th>
<th>Service: Health visiting</th>
</tr>
</thead>
</table>

**Key learning for Oxleas**

| Referrals and parental consent | Multi-agency safeguarding hub (MASH) workers should be clear about parental consent when referring to children’s social care and obtaining information. The role of fathers should be explored. |
| Unexplained/unwitnessed injuries | Professional curiosity is important for unexplained injuries. Practitioners to be alert to the possibility that initial conclusions may be incorrect. Strategy meetings to be convened including health and police colleagues. |

<table>
<thead>
<tr>
<th><strong>Bromley Serious Case Review</strong></th>
<th>‘Elizabeth’</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Published in August 2018</td>
</tr>
</tbody>
</table>

**Background**
Elizabeth was killed by a 16 year old friend at his home in Surrey in 2014.

<table>
<thead>
<tr>
<th><strong>Datix Web 56049</strong></th>
<th>Services: History of involvement with CAMHS (2011-2012)</th>
</tr>
</thead>
</table>

**Key learning**

| Communication | Some aspects of Elizabeth’s experiences and agencies’ responses to them indicated a heightened level of vulnerability and some potential advantage might have been gained had there been more information exchange and multi-agency communication. |
| Response to vulnerability | Opportunities for improvements in the way services recognise and respond to vulnerability (in particular record keeping and its communication) have been identified and inform the recommendations. |
| Conclusion | This SCR was focused upon Elizabeth’s experiences of service delivery (as opposed to those of her killer). Nothing has been found to indicate an acute physical risk to Elizabeth from another person and no alternative responses by any of the agencies with which she (or her family) were involved could have served to predict or prevent her murder. |
## Multi-agency Learning reviews started between April 2018- March 2019

<table>
<thead>
<tr>
<th>Borough</th>
<th>Case</th>
<th>Status/ Learning</th>
</tr>
</thead>
<tbody>
<tr>
<td>Bexley</td>
<td>Child AMM</td>
<td>Put on hold due to care proceedings</td>
</tr>
<tr>
<td></td>
<td>Aged 7 weeks suffered hypoxic brain injury</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Aged 7 weeks presented to A&amp;E with a suspected non-accidental injury</td>
<td>Learning: There was not sufficient professional curiosity regarding the father of Baby G. Partner agencies did not escalate concerns regarding poor communication, and/or contact, and/or attendance at the strategy discussion immediately after Baby G was admitted to hospital.</td>
</tr>
<tr>
<td></td>
<td>‘Baby L’</td>
<td>Awaiting publication</td>
</tr>
<tr>
<td></td>
<td>3 month old baby attended A&amp;E with a suspected non-accidental injury.</td>
<td></td>
</tr>
<tr>
<td>Bromley</td>
<td>‘George’</td>
<td>In progress</td>
</tr>
<tr>
<td></td>
<td>19 year old with a history of somatic symptom disorder/possibly fabricated illness.</td>
<td></td>
</tr>
<tr>
<td></td>
<td>‘Matthew’</td>
<td>In progress</td>
</tr>
<tr>
<td></td>
<td>Unexpected death of a 5 year old with cerebral palsy. Mother open to Bromley Adult Mental Health.</td>
<td></td>
</tr>
<tr>
<td></td>
<td>‘Natalie’</td>
<td>Awaiting publication</td>
</tr>
<tr>
<td></td>
<td>A review of multi-agency response to mother’s concerns about her 4 year old daughter who was deemed at risk of FGM</td>
<td></td>
</tr>
<tr>
<td></td>
<td>‘Leo’</td>
<td>Published in September 2018.</td>
</tr>
<tr>
<td></td>
<td>17 year old who was stabbed by a number of youths in 2017.</td>
<td></td>
</tr>
</tbody>
</table>
Lessons learnt:

- There is a need to ensure that clinicians are explicitly justifying decisions to remove cases from ADOS/assessment waiting lists as standard, with clear documentation on RiO.

- There is a need to significantly improve administrative support for the Complex Communication Diagnostic Service referrals meeting.

### Safeguarding Children Audit Activity 2018/2019

#### Internal Audits
- Children in adult network audit - Adult mental health services
- Safeguarding children in supervision Adult mental health services
- KPMG Safeguarding children and adults referrals to social care
- Safeguarding supervision audit (Greenwich)

#### Multi-Agency Audits

**Bexley:**
- Adolescent risk
- Improving Multi-agency planning and decision making in Child Protection Conferences.

**Greenwich:**
- Multi-Agency ‘Deep Dive’ Audit into High Risk Adolescents

**Bromley:**
- Drug and alcohol misuse – impact on children
- Vulnerable adolescents
• **Inspections and Reviews**

February 2018 - Ofsted, the Care Quality Commission (CQC), HMI Constabulary and Fire & Rescue Services (HMICFRS) and HMI Probation (HMI Prob) undertook a joint inspection of the multi-agency response to children who go missing, who are at risk of child sexual exploitation and who are at risk of criminal and other forms of exploitation through gangs. The inspection included a ‘deep dive’ focus on a number of cases in which these issues were known to be concerns where children were involved. The overall feedback was positive highlighting commitment to joint working across agencies.

July 2018 – Ofsted inspection of Bexley children’s social care services receiving outstanding rating.

November 2018 – Ofsted inspection of Bromley children’s social care services receiving good/outstanding rating.

6.0 **Engagement with Service Users**

We currently have a number of methods of gathering user feedback and structures that allow us to systematically analyse, report on and respond to this feedback. At a service development level we often undertake one-off feedback exercises through online surveys, paper questionnaires and focus groups about areas of our services that we feel may need improvement. This work is overseen by the Patient Experience Group (PEG), made up of senior staff from across our Children and Young People’s Directorate. All feedback received through surveys etc. along with complaints, compliments and informal grumbles are taken to monthly meetings where they are discussed and action plans are set.
7.0 Priorities for the Year Ahead

1. Basic safeguarding and child protection practice across services underpinned by the Think Family approach
   - Focus on ensuring robust safeguarding practice including clarity and consistency of processes for record keeping, information sharing, children’s social care referrals and child death and RIO documentation of children within adult networks.
   - Raise awareness of the role of fathers and men in families
   - For adult mental health staff to consider service users as parents and risks to children.

2. Perinatal mental health and vulnerabilities of under 1’s
   - Raise awareness of mental health difficulties in pregnancy and postpartum and potential impact on parenting capacity and mother-infant and family relationships
   - Raise awareness of the link between adverse childhood experiences (ACEs) and mental health difficulties
   - Continue to raise awareness of vulnerabilities of babies under 1 year old

3. Children with specific vulnerabilities (including contextual safeguarding) and complex health needs
   - Continue to develop practitioner confidence in recognising and addressing risks associated with extra-familial risks, such as FGM, Exploitation, CSE, Missing, Gangs and Radicalisation.
   - Develop the role of a health coordinator for children with complex and chronic health needs
   - Raise awareness of safeguarding issues of children who are disabled

4. Adolescent neglect and emotional wellbeing with focus on self-harm
   - Continue to raise awareness of Adolescent neglect and emotional wellbeing, particularly self-harm
   - Introduce additional support to CAMHS services through provision of additional consultation
5. Continue to promote culture of learning that arises from child safeguarding reviews, audits and inspections

- Actively contribute to Child Safeguarding Reviews, Multi-agency Audits, inspections and other relevant forums and provide a variety of ways to disseminate learning.

- Work in collaboration with Oxleas Safeguarding Adults team towards embedding Think Family Safeguarding

- Promote partnership working

8.0 Conclusion

Oxleas vision and the challenge for safeguarding children remain unchanged; that is to ensure safeguarding and promoting the welfare of children is embedded across every directorate and in every aspect of the work of the trust. The priorities for the coming year will build on the successes of the previous while at the same time acknowledging key improvement areas.
Report Title | Quality Improvement and Innovation Report  
Author | Vicky Ellis, Associate Director of Quality Assurance and Improvement  
Accountable Director | Dr Ify Okocha – Medical Director  
Confidentiality/FOI status | public

| Report Summary | The Trust Quality Improvement and Innovation Committee met on the 27th of November 2019 and highlights are as follows;  
1. Quality Improvement and Innovation in Action  
Two Qi projects were presented to the Committee:  
1.1. Heath Ward – Learning from Qi involvement.  
Heath Ward is a 16 bedded female acute admissions unit with a number of presenting challenges including high levels of safeguarding concerns, substance misuse and difficult staff and patient dynamics. Heath Ward did not formally take part in the trust wide reducing violence and aggression Qi project. The team presented to the committee on what they did as an alternative to address some of these concerns.  
A whole team approach was taken to identify areas of risk on Heath Ward and an away day was held with a focus on patient safety. During this away day, training was delivered on safeguarding, communication styles, working with personality disorder, the Broset checklist and safe therapeutic boundaries.  
Following this, action plans and learning from the trust-wide Qi project were adapted and implemented on Heath Ward. These included pre-admission conferences, my crisis plans, safety huddle meetings and the Broset reducing violence checklist.  
Heath Ward is now recording a significant reduction in safeguarding incidents, a better use of positive behaviour plans and better MDT attendance at reflective practice sessions.  
Next steps for Heath Ward include, making a decision whether to join the trust-wide reducing violence Qi project or to register a new Qi project specifically for Heath Ward.  
1.2. Optimizing medicines for people with schizophrenia  
The aim of this project was to increase prescribing of depot antipsychotics and clozapine, maximise adherence, reduce acute bed occupancy and discharge stable patients on a depot to primary care.  
Since May 2018 a number of outcomes have been observed. These include an increase
in depot and clozapine prescribing and a reduction in occupied bed days by 7% (saving of £750k per year). There has also been a focus on reducing attrition from the depot and this is now 20% rather than 40%. The next stage is to scale this up to see if the effects are real.

Regarding clozapine, it is understood that fewer patients default from structured care in a clozapine clinic than in routine care.

The next PDSA cycle for this project will involve increasing staff confidence in dealing with side effects from clozapine if they are detected. Further to this, work needs to be done regarding how GP’s record that a patient is on clozapine. At present it is recorded in such a way that it is not pulled through onto the ‘summary care record’. This means that if a patient presents at A&E, staff may not know they are on clozapine.

2. Directorate Update

Bromley directorate provided an update on their Qi Programme. The Quality governance framework has been split into Quality Assurance and Quality Improvement meetings that meet bimonthly. The Quality Improvement meeting has good attendance from professional and operational leads and feedback from teams is presented. The DMT have received Qi training and are visible sponsors of Qi.

There are currently 13 active projects and 5 proposed. Of those active, nine are in the testing phase and 3 are showing modest improvements.

144 staff in Bromley have received Qi training which equates to around 39% of the directorate.

3. Qi programme update - Embedding a culture of continuous quality improvement

848 staff have received internal Qi training. This represents 24% of Oxleas substantive staff, however this does not take into account staff who have left the trust.

There are 80 active Qi projects, 61 proposed and 12 completed. This is an increase of a total of 26 projects since the last Qii committee meeting in September.

The second annual SLP Qi conference was held on the 21st November 2019. 300 delegates attended and there were 9 breakout sessions, 5 plenary speakers and 30 posters submitted for a poster competition.

The first SLP Safety Collaborative workshop was held on 6th November 2019. This collaborative was formed with the aim of enabling a collective approach to focusing on safety in teams across the three trusts. This model is centred on quarterly collaborative meetings in which nine teams from across the partnership come together for a workshop and learning event. In between workshops teams are supported by quality improvement coaches and local leadership.

An SLP intermediate level Qi training programme is being developed and will be known as the ‘SLP Qi Academy’. This will equip participants with the skills and knowledge
required to be an additional directorate resource to support Qi efforts. Three cohorts will run in 2020 and Oxleas has spaces for 8 participants per cohort.

The number of Qi projects with service user involvement has been steadily increasing each month since May 2019. It is expected that the training that is currently being co-designed will further support an increase in co-produced Qi projects.

<table>
<thead>
<tr>
<th>Purpose (To select purpose, click on relevant choice for drop down box)</th>
<th>Information</th>
<th>To Note</th>
<th>Approval</th>
<th>Decision</th>
</tr>
</thead>
</table>

| Recommendation | The Board is asked to note the report |

<table>
<thead>
<tr>
<th>Link to strategic objectives (click on relevant choice for drop down box)</th>
<th>Quality</th>
<th>Workforce</th>
<th>Sustainability</th>
<th>Partnerships</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Link to Board Assurance Framework</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Implications</th>
</tr>
</thead>
<tbody>
<tr>
<td>Quality</td>
</tr>
<tr>
<td>Financial</td>
</tr>
<tr>
<td>Equality analysis</td>
</tr>
<tr>
<td>Service user/carer/staff</td>
</tr>
</tbody>
</table>
Report Title: Finance Update (19th November & 17th December Meetings)

Author: Alex Owoo – AD Financial Management & Planning

Accountable Director: Jazz Thind – Director of Finance

Confidentiality/FOI status: N/A

Report Summary:

Financial Performance to Month 8 (November 2019)

For the 8 months to the end of November 2019 the Trust delivered an underlying deficit position of £1.1m (before PSF); this is £940k behind the YTD planned deficit of £152k; and has been fully offset by the use of non-recurrent mitigations securing £1.15m of PSF YTD.

Key highlights:

- On-going volatility in the usage of non-Oxleas MH beds with Greenwich remaining the area of focus. November saw an overall improvement in demand for Adult Acute non-Oxleas beds with a reduction of 228 bed days compared to October (with Bexley managing within its commissioned bed base)
- Non delivery of saving plans continues to feature as a key reason for the need to draw down non-recurrent support. The formulation and delivery of sustainable savings plans remains the most significant financial risk with all services being asked to hold underspends and improve these where possible to offset some of the in-year slippage savings
- Rowan House sale completed on the 15th November. Profit on asset sale cannot be counted towards the delivery of control total
- MHIS funding is now being fully utilised in relation to the schemes identified
- Delivering an on-plan FOT secures a further £0.9m of core PSF and as in previous years the Trust may be eligible to be allocated a share of any potential PSF bonuses should these become available. 2019/20 is the last year of PSF.

Pensions tax impacts on clinicians - the proposed solution for 2019 / 20

The Committee noted the recent update from NHSE/I regarding the decision to provide a short-term solution that deals with the personal tax liability arising in 19/20 associated with those that meant the definition of being a ‘clinician’. The proposed solution is:
“Clinicians who are members of the NHS Pension Scheme and who as a result of work undertaken in this tax year (2019/20) face a tax charge in respect of the growth of their NHS pension benefits above their pension savings annual allowance threshold will be able to have this charge paid by the NHS Pension Scheme (by completing and returning a ‘Scheme Pays’ form before 31 July 2021) meaning that they don’t have to worry about paying the charge now out of their own pocket

and

The NHS employer will make a contractually binding commitment to pay them a corresponding amount on retirement, ensuring that they are fully compensated in retirement for the effect of the 2019/20 Scheme Pays deduction on their income from the NHS Pension Scheme in retirement.

This scheme will be implemented with no net cost to Trusts or CCGs.”

Bids and Tenders
Start Well Greenwich
The three successful organisations have been contacted for a meeting to organise the details of the transfer. In addition, the Trust met with RBG, the new IT system host, and started the work to ensure a smooth transfer of data.

Young Greenwich
Negotiations have gone well with the decision to be made by the 20th January 2020.

Bromley 0 -19
The Committee noted the disappointing outcome of the tender resulting in Oxleas no longer retaining this service contract, and asked the Executive to contact London Borough of Bromley for a face to face feedback meeting post standstill period.

Specialist Forensic Community Teams
Mobilisation work streams have commenced. Additional funding to support ‘advancing equalities’ is being made available and work is underway to assess how we deliver this aspect.

Kent Prisons
NHSE has published its intent to commence a procurement exercise for all seven of the prisons within the Kent geographical footprint. Oxleas currently operates in all seven prisons providing mental/physical health services; either as Oxleas or through a number of established partnerships. ITT is due to be released by May 2020.
2020-21 Draft Financial plan
The Committee received a report on the draft financial plan for 20/21 (previously shared at the January Board strategy day) indicating a financial gap of £13.4m. This is the level of efficiency required to meet the assigned trajectory of breakeven. The Committee supported the draft options to mitigate the gap and asked the Executive to feedback the final outcome from the January Strategic Executive meeting.

The SEL STP still has a significant financial gap which it needs to close. Discussions are underway to assess how this is achieved.

Improving the financial position
The Committee noted and commended the work undertaken on the ‘improving the financial position’ paper and discussed each of the 5 opportunities and the work required to finalise financial contribution available from each to support the 20/21 financial plan.

Bed Programme update
The Committee noted the work being undertaken with regards to better management of mental health beds; resulting in increased focus on:
- Decision making at the point of admission
- Flow
- Discharge processes and how this is standardised across boroughs

SLP Finance update
The Committee received an update on SLP finances which shows an improving picture with regards to CAMHS and Forensics. A key variant to the FOT is the outcome of the discussions with regards to savings generated within the Complex Care programme. The Committee asked for a review of the governance to ensure future updates includes any reversal of decisions taken – e.g. the decision to no longer open additional MSU capacity previously approved.

OPS update
The Committee noted the update for OPS and asked the Executive to consider actions/options that will facilitate OPS mitigating future/accumulated losses to allow it to improve its competitive edge and reinvest into service developments.

SARD update
The Committee approved in principle the sale of ordinary shares in SARD to Mango Swiss reducing the Trust holding by 53%. The Trust directors will remain on the Board of SARD and although they will no longer have voting right, a legal document is being drawn up to allow a ‘veto’ to be exercised where a decision adversely impacts the reputation of the Trust. The financial transaction will subject to the finalisation of this document. Sign off date January 2020.
**2020-21 Contracts Update**

The Committee noted the latest outcome on contract negotiation with SEL CCGs and NHSE. The discussions with SEL have been positive with the Trust receiving the appropriate uplift with regards to MHIS and growth funding for CHS both of which are over and above national business rules. A 0.5% ‘top sliced’ SEL STP contingency has been created, and will be made available to all, to help deal with any key pressure, with any unutilised fund returned on a prorate basis at the end of the year. The funding of non-block charges continue to be discussed with the aim of including as much of these charges as possible into the overarching block cash envelope.

<table>
<thead>
<tr>
<th>Purpose (To select purpose, click on relevant choice for drop down box)</th>
<th>Information</th>
<th>To Note</th>
<th>Approval</th>
<th>Decision</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Recommendation</th>
<th>The Board is asked to note the update.</th>
</tr>
</thead>
</table>

**Link to strategic objectives (click on relevant choice for drop down box)**

| Quality | √ | Workforce | √ | Sustainability | √ | Partnerships | √ |

**Link to Board Assurance Framework**

| 1291 – Achievement of CQUIN income | 1177 – Non achievement of savings plans | 1565 – Collective responsibility within for STP within the SEL footprint | 1606 – Reliance on non-Oxleas beds |

**Implications**

| Quality | The aspiration to deliver high quality care may be compromised |
| Financial | Unless the Trust is able to deliver services within the defined levels of funding and meet its Control Total, there would be greater financial scrutiny from the Regulator |
| Equality analysis | Service user and carer experience and support may be reduced with safety being the key focus. Staff morale may be impacted. |

| Service user/carer/staff | |

---
Finance Report for 8 months to 30\textsuperscript{th} November 2019

Board of Directors

9 January 2020

Financial overview 2
NHSI Finance and Use of Resources Score 4
Statement of Comprehensive Income 5
Statement of Financial Position (Balance Sheet) 6
Capital Investment 7
Risk Register 8
Appendix 1: Operational Performance 9
Appendix 2: 19/20 Savings Target and Plans 10
Appendix 3: Agency Analysis 11
Appendix 4: UEA 12
Appendix 5: Draft FOT 13
Financial Overview

Control Total

Planned surplus of £1.9m – underlying deficit of £0.2m; provider sustainability funding (PSF) of £2.1m.

For the 8 months to the end of November 2019 the Trust delivered an underlying deficit position of £1.1m (before PSF); this is £940k behind the YTD planned deficit of £152k; and has been fully offset by the use of non-recurrent mitigations securing £1.1m of PSF YTD. Profit on asset sales in relation to Rowan House cannot be counted towards the delivery of Control Total.

Key highlights:-

- The Trust continues to experience volatility in the usage on non-Oxleas MH beds, with a task and finish group overseeing Greenwich borough. November saw an overall reduction of 228 bed days compared to October and with Bexley using no non-Oxleas beds.
- A number of inpatient wards continue to report an overspend with patient acuity and specialising being sited as the key drivers. The initial results from the MHOST toolkit are being triangulated to assess the reality of acuity levels and validation of costs incurred.
- Failure to deliver savings plans continues to feature as a key contributor to the adverse financial performance. The biggest financial risk remains the formulation and delivery of sustainable savings plans for 20/21 and beyond.
- Unallocated central reserves continue to subsidise overspends, these are however not sufficient to offset 100% of the financial risk hence the need to use non-recurrent mitigations.
- There was an overall reduction in the use of staffing costs in November with agency spend now 30.9% below the assigned threshold.

Forecast Outturn

The Trust is forecasting to deliver the underlying planned deficit of £187k (which secures £2.1m of PSF). Delivering the Control total may also influence access to a share of the ‘Bonus PSF’ as attained in previous years. Remaining on plan is challenging and meeting the plan will rely on further estimated non-recurrent mitigations worth £1.3m (this is greater than the average drawn down to date as it assumes spikes in spend with regards to beds and some seasonal pay pressure).

CREs

The savings target for 19/20 equates to £9.4m, and includes any underachievement from 18/19. Savings proposals to the value of £4.1m FYE are now delivered or being mobilised with continued Quality Impact Assessments (QIA) being undertaken to ensure the mitigations set out to deal with any negative impact continue to be successful. The identification and delivery of CREs is a significant risk but developing schemes is fundamental to ensuring the Trust is able to sustain a underlying position of breakeven. £5.3m of unachieved efficiencies will be carried forward into 20/21 and continuing to manage slippage through non-recurrent actions is not sustainable.

NHSI Metric

Under the Single Oversight Framework, the Trust scores a ‘1’ against the ‘Finance and Use of Resources Metric’ (plan ‘1’), see comments above regarding non-recurrent support.
Risks

- Plan assumes the impact of the new AFC pay deal for AFC staff working in L.A. commissioned contracts is fully funded. The Trust received £0.6m of transitional support to offset this pressure. The value was calculated using the same principles as those applied to CCG contracted services leaving a residual unfunded cost pressure of £0.4m., this is subsumed in the reported position.
- Plan assumes 100% delivery of CQUIN; the Flu CQUIN remains the highest risk (£0.7m); plans to maximise CQUIN income continue to be mobilised.

Emerging risks

- In June 2019, the court of Appeal ruled in favour of NHS employees working for East of England Ambulance Service in the case – N Flowers and others V East of England Ambulance Trust. The finding was that staff who regularly undertake overtime or work beyond their normal shifts should have these hours taken into account when calculating holiday pay. HR colleagues have confirmed this is only applicable to substantive staff undertaking bank/overtime shifts; estimated pressure of £0.6m.
- Future funding with regards to the 6.3% increase in employer pension contributions; and AFC funding associated with pay costs of LA commissioned contracts, not yet known.
- Operating a year-on-year I&E position with a underlying deficit (offset by non-recurrent support) will have an impact on future cash balances and thereby the Trust’s ability to meet the proposed future capital expenditure plan. The capital plan is however not fixed and expenditure will be prioritised to ensure it is affordable.

Capital

YTD capital expenditure is 3% behind plan and is primarily due to phasing. The majority of planned spend is in relation to the redevelopment of the Queen Mary’s site at Sidcup which benefits a number of other providers (NHS and Non-NHS). The Trust had reviewed all commitments to assess any opportunities to support the closing of the national CDEL gap, although this request was subsequently withdrawn, the majority of the proposed reductions remain in place resulting in a revised FOT of £17.7m (previously £20.7m). This revised position represents the most realistic outturn at this point in time and excludes changes associated with the new PDU development. Rowan House was sold at auction on 31st October 2019 for £0.86m, resulting in a profit on asset disposal of £0.54m.

Cash

Total cash and short term investments held are £64.6m against a plan of £47m (excluding Charitable funds) at the end of November 2019.

Our medium term cash plan, once we have allowed for further capital commitments will leave the Trust holding approximately £24m in cash. This reflects the cash buffer required to ensure the Trust is able to support and manage its day to day operations (salaries; creditor payments etc.) for a period of 2 months and not experience any issues with liquidity.

Better Payment Practice Code

The public sector payments target is that 95% of invoices are paid within 30 days of receipt of goods or a valid invoice. In November 89% of invoices by volume and 88% of invoices by value were paid within the target, a small improvement on October.

NHSI Segmentation - Providers are assigned an overall ‘segment’ taking into account scores attained across 5 core themes, with ‘Finance and the use of resources’ being one of these. Segment 1 means complete autonomy and a segment rating of 4 would lead to special measure being instigated.

‘Finance and use of resources’ theme is made up of the metrics detailed in the table below. Each metric has been assigned an equal weighting. A score of 1 is the ‘best’ and 4 the ‘worst’.

Scoring a ‘4’ on any metric caps the overall score to at most a ‘3’, triggering a concern.

The SOF has been updated and this theme will be disaggregated into 2 scores. The ‘Finance’ score will be based on the metrics already in place below. The ‘Use of Resources Assessment’ will be used to improve understanding of how effectively and efficiently trusts are using their resources (including finances, workforce, estates and facilities, technology and procurement) to provide high quality, efficient and sustainable care for patients. Work to evaluate our position against the ‘Use of Resources Assessment’ metrics continues.

<table>
<thead>
<tr>
<th>Area</th>
<th>Financial and use of resource metrics</th>
<th>YTD</th>
<th>Score</th>
<th>Weight</th>
<th>Score 1</th>
<th>Score 2</th>
<th>Score 3</th>
<th>Score 4</th>
</tr>
</thead>
<tbody>
<tr>
<td>Financial sustainability</td>
<td>Capital Servicing Capacity Rating (times)</td>
<td>Actual Plan</td>
<td>2.65</td>
<td>1</td>
<td>20%</td>
<td>&gt;2.5x</td>
<td>1.75-2.5x</td>
<td>1.25-1.75x</td>
</tr>
<tr>
<td>Financial sustainability</td>
<td>Liquidity Rating (days)</td>
<td>Actual Plan</td>
<td>24</td>
<td>1</td>
<td>20%</td>
<td>&gt;0</td>
<td>-7 to 0</td>
<td>-14 to -7</td>
</tr>
<tr>
<td>Financial efficiency</td>
<td>I&amp;E Margin (%)</td>
<td>Actual Plan</td>
<td>0.3%</td>
<td>2</td>
<td>20%</td>
<td>&gt;1%</td>
<td>0% to 1%</td>
<td>-1% to 0%</td>
</tr>
<tr>
<td>Financial Controls</td>
<td>Distance from Financial Plan (%)</td>
<td>Actual Plan</td>
<td>0.0%</td>
<td>1</td>
<td>20%</td>
<td>&gt;0%</td>
<td>-1% to 0%</td>
<td>-2% to -1%</td>
</tr>
<tr>
<td>Financial Controls</td>
<td>Agency Spend (%)</td>
<td>Actual Plan</td>
<td>-30.8%</td>
<td>1</td>
<td>20%</td>
<td>&lt;0%</td>
<td>0% to 25%</td>
<td>25% to 50%</td>
</tr>
</tbody>
</table>

Financial and use of resource rating November 19 | Actual Plan | 1 | 1 |

improving lives
• **YTD** - the Trust delivered an underlying deficit position of £1.1m (before PSF); this is £940k behind the YTD planned deficit of £152k; and has been fully offset by the use of non-recurrent mitigations securing £1.1m of PSF YTD. Profit on asset sales in relation to Rowan House cannot be counted towards the delivery of Control Total.

• **PSF** - This is contingent on the Trust achieving its underlying financial position. PSF YTD equates to £1.1m; a cash payment of £313k has been received for Q1 with Q2 approved for payment.

• **Income**: £2.9m ahead of plan
  - £0.9m QMH; £0.5m OPS recharges; and deferred income releases offsetting equal and opposite amounts in expenditure;
  - additional activity based income generated by Bexley MSK, Children Services; draw down of transformation funding; recharges associated with non-BBG patients placed in non-Oxleas beds
  - deterioration in income generation in Tarn, Atlas House, Oaktree Lodge and routine NCA income across all boroughs

• **Pay**: £0.5m - overall in month pay spend is in line with the average pay spend in the first four months of the year. Acuity and use of specialising in inpatient wards continue to be the main cost drivers for why majority of the wards are reporting overspend positions. However, this increased demand has been covered using either substantive staff or bank shifts.

• **Non-pay**: £3.2m overspend - excluding those costs offset by income above the key driver is the non delivery of savings held centrally and the on-going reliance on additional MH beds. The focus on use of private beds has yielded some upside with the Trust using 228 less bed days than October (443 OBDs) and Bexley not utilising any private adult acute beds in the month.

• **Agency Cap**: agency spend now stands at 30.9% below the NHSI assigned threshold. The agency panel continues to meet to scrutinise requests for all non-nursing roles. The Trust has not been issued with a threshold for medical agency however the spend year to date is £144k higher than the corresponding period in the last financial year. November 19 had the second lowest monthly spend since NHSI introduced the agency cap.
Statement of Financial Position

Debt summary
- Total debt stands at £14.4m, an increase of £4.6m from October. Majority of this relates to catch up charges in relation to the Wandsworth Prison contact (£3m) and SLP Adults Secure (£1.2m). £7.3m of the total debts is <30 days and £2.8m of the debts has been settled in December.
- Debt > 90 days £3.4m.
- Material debts that are a cause for concern and/or an area of concerted effort are noted below:
  - Southwark and Lewisham CCGs: £0.2m and £0.4 respectively; debt relates mainly to NCA activities. Dispute resolution expected in December with appropriate payments received and CRNs issued where charges were deemed erroneous. The assistance of collaborative working with other STP CCG finance lead has been helpful in getting to this point.
  - Bromley CCG: £0.3m. The dispute relates to the diagnosis of three patients not covered by the female PICU agreement. The Finance team and the Service Managers are liaising with CCG to resolve.
  - Greenwich CCG: £0.8m. Dispute in relation to patients placed in Barefoot Lodge is still on going, disputed invoices amount to £0.3m, dispute has been escalated to DoF who is liaising with counterpart at the CCG to resolve the issues. £0.3m of other debts has been paid in December.
  - Bridges Healthcare Services: £0.3m. The liquidator report confirms further investigation is needed into a number of transactions which will take a further year to complete.

Payments
- The public sector payments target is that 95% of invoices are paid within 30 days of receipt of goods or a valid invoice. In November 89% of invoices by volume and 88% of invoices by value were paid within this target.
QMH Redevelopment

- Phase 2: The Queen Mary’s Hospital Development Plan (business case) approved by the Board of Directors, on the 3 May 2018 with a capital cost of £15.8m.

Primary projects in Phase 2:

- Redevelopment of the second floors: Contract start date 02 Oct 18 and are now complete. Dental and ophthalmology have relocated onto their new departments on the 2nd floor. The dental lab, administrative team and friends kiosk are still to be relocated.

- Foxbury – Phase 2 work onsite

- Demolition of Block A & level 3&4 works: Demolition of A Block: Options appraisal being compiled examining demolition verses refurbishment. Feasibility to relocate Pinewood House being examined. Main Building Works level 3&4: works to relocate Diabetes from A block to level 2 B Block currently in design, awaiting confirmation of continuation of service from provider. Works to accommodate various admin teams on level 3 in design stage.

- Theatres: M&E specification being audited by new consultants with a retender exercise due to start in Feb 2020. Work is now not anticipated to start on site until Q2/3 2020.

- Capital Replacement Projects: (Budget £0.5m): Pharmacy Dispensary design being finalised then will be procured by traditional tender. Lifts modernisation - works required to electrical infrastructure have delayed start on site. Works to start in Q1 2020.

- Alliance Medical now have ownership of I block, and will be commencing work in January. Work also continues to work up the plans for future MRI provision at QMH.
Financial risks scoring 8 or above and not yet achieving ‘target’ risk rating have been included in this section. The table below represents the latest position of LIVE risks ratified at the October 2019 meeting of the Business Committee.

<table>
<thead>
<tr>
<th>Risk Theme/Area</th>
<th>Risk Description</th>
<th>Level &amp; Rating (C x 1)</th>
<th>Changes since last review</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cash Releasing Efficiencies</td>
<td>1177: Not achieving the savings required to deliver the control total would have a negative impact on the recurrent deliverability of our operational financial plan and raise questions about our long term sustainability.</td>
<td>Significant (16) (4 x 4)</td>
<td>↔</td>
</tr>
<tr>
<td>Achievement of CQUIN Income</td>
<td>1291: There is a risk that we will not achieve 100% of the CQUIN value. This could result in a loss of income.</td>
<td>Significant (16) (4 x 4)</td>
<td>↔</td>
</tr>
<tr>
<td>Changes in Commissioning structures</td>
<td>1292: The last round of changes to commissioning structures meant a number of services (mainly CYP) are now commissioned by Local Authorities (previously via CCGs). LA commissioners continue to review service delivery in detail and service specifications for contracts due for renewal are being updated and retendered with either - reduced funding; contract retainers; increased delivery expectations; and fixed cash envelopes that provide no flexibility to negotiate resources where there has been national agreements that increase the cost base (e.g. AFC pay deals; employer pension contributions)</td>
<td>Moderate (8) (4 x 2)</td>
<td>↔</td>
</tr>
<tr>
<td>Collective responsibility for delivery of SEL STP CT</td>
<td>1565: The STP expects organisations with the SEL footprint to take on a collective responsibility in identifying further opportunities (over and above those factored into operational plans) to address the financial difficulties within the system. Current net STP collective ‘constrained’ gap equates to £74m. All individual organisations within the STP need to support the changes required to improve financial performance and may be asked to take part in financial risk/gain shares that incentivise the right behaviour to close the gap.</td>
<td>Moderate (9) (3 x 3)</td>
<td>↔</td>
</tr>
<tr>
<td>Inpatient Bed Management</td>
<td>1606: The Trust continues to rely on non-Oxleas beds (NHS and non-NHS) to manage Inpatient demand and changes associated with MHA. If the Trust is unable to reduce demand through the deployment of admission avoidance strategies, this will continue to create a cost pressure and impact on the overall financial position of the Trust.</td>
<td>High (12) (4 x 3)</td>
<td>↔</td>
</tr>
</tbody>
</table>
Appendix 1

**CYP: **£705k underspend

The YTD income over-performance is largely driven by Bromley CAMHS (transformation income); immunisation funding; IAPT pump prime funding; non-pay (£330k); offset by a staffing underspend of £61k (agency staff premium) and unachieved clinical productivity savings £35k. The underlying YTD underspend position is due to the RBG universal services (recently re-tendered); which accounts for £655k of this underspend.

**Forensics: **£39k overspend YTD

Overall income is £50k above target due mainly to overseas income; TILT occupancy remains below plan with the service model under review. Temporary staffing cover has increased due to observations; long term segregation and sickness which the service is investigating. Catering provision continues to overspend (£128k YTD) Finance in collaboration with colleagues in Estates and Forensics are undertaking a deep dive into the main drivers with a view to either reducing the associated cost or recognising under-funding.

**South London Partnership: **£43k Overspend

This will be offset as part of the quarterly SLP reconciliation.

**Prisons: **£400k overspend YTD

Staff costs are over plan as a result of the use of bank and agency staff to provide cover for substantive staff shortages during a period of increasing demand. The additional staff use is driven by an increasing demand which is significantly different to the original modelling. This has been raised with commissioners and they have committed to undertake a review of the health needs analysis taking into account these changes. The Greenwich cluster contract runs until March 2022. Measures have been put in place to alleviate the financial pressures, including the reduction of 2 WTE bank staff each week in Thameside so that by the end of January 2020, there will be a reduction of 10 WTE.

**Adult LD: **£406k underspend

Vacancies in nursing, psychology & OTs is driving the underspend. Atlas House income worsened this month with one more ECR patient discharged, however there are two possible new referrals in the pipeline. There are currently 5 empty ECR beds.

**Greenwich: **£2,108k overspend

The underlying overspend is £936k once £1.2m of inter-borough recharges are excluded. This is predominantly due to the usage of additional non-Oxleas MH beds (£848k) with November seeing a decrease in pressure resulting in a lower cost of £127k (146 OBDs). Income generation remains a challenge for a number of service lines (Oaktree, MSK & The Tarn) and is £838k; however this is behind plan. Ward pay overspends are due to extra staffing to deal with acuity and specialising of patients on the medical wards at QE and the continued reliance on 6 locum doctors. Efforts to transition agency doctors into NHS Locums are proving challenging,

**Bexley: **£230k underspend

The YTD underspend is largely driven by an inter borough costs transfer between Greenwich Borough and Bexley for Oxleas bed usage, resulting in a £768k credit to Bexley. Excluding this transaction, the underlying Bexley position is £537k overspend. The overspend position is mainly due to the following: 1) Use of temporary staffing to cover for vacant posts and long-term sickness, particularly within the District nursing team (twilight team and night service). In addition the services continue to over-perform beyond commissioned activity. Discussion with GP to address referrals are on-going. 2) Under achievement of CRE plans. and 3) Use of private beds (worth noting that Bexley did not use any adult acute UEA in M8).

**Bromley: **£103k underspend

The underlying position is a £280k overspend once £404k of the cross borough recharge benefit is removed. This overspend is due mainly to additional staffing on AMH wards (£281k) to cover acuity and the escorting of patients to the acute hospital. 4 Female PICU placements are proving challenging to repatriate however, the service continues to engage with colleagues internally and SLP to speed up step down into appropriate placements.

**HQ Services **£477k underspend

The underspend is largely driven by vacancies; the majority of which are likely to be recruited to.
### Appendix 2 - 19/20 Savings Target and Plans

**FYE Current plans; Financial Risk Rating; Gap**

<table>
<thead>
<tr>
<th>Directorate</th>
<th>Plans/Target</th>
<th>Green</th>
<th>Amber</th>
<th>Red</th>
<th>Identified</th>
<th>Unidentified</th>
<th>In Yr Impact</th>
</tr>
</thead>
<tbody>
<tr>
<td>Bexley</td>
<td>491</td>
<td>480</td>
<td>11</td>
<td>491</td>
<td>333</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Bromley</td>
<td>201</td>
<td>201</td>
<td></td>
<td>201</td>
<td>99</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Greenwich</td>
<td>793</td>
<td>764</td>
<td></td>
<td>764</td>
<td>298</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Children &amp; Y.P. Services</td>
<td>761</td>
<td>761</td>
<td></td>
<td>761</td>
<td>709</td>
<td></td>
<td></td>
</tr>
<tr>
<td>LD</td>
<td>22</td>
<td>22</td>
<td></td>
<td>22</td>
<td>0</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Forensic &amp; Prisons</td>
<td>577</td>
<td>577</td>
<td></td>
<td>577</td>
<td>365</td>
<td></td>
<td></td>
</tr>
<tr>
<td>South London Partnership (SLP)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Subtotal</strong></td>
<td><strong>2,844</strong></td>
<td><strong>2,804</strong></td>
<td><strong>11</strong></td>
<td><strong>2,815</strong></td>
<td><strong>5,322</strong></td>
<td><strong>1,804</strong></td>
<td></td>
</tr>
<tr>
<td>Estates</td>
<td>869</td>
<td>869</td>
<td></td>
<td>869</td>
<td>824</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Finance</td>
<td>245</td>
<td>81</td>
<td></td>
<td>81</td>
<td>0</td>
<td></td>
<td></td>
</tr>
<tr>
<td>HR</td>
<td></td>
<td>23</td>
<td></td>
<td>23</td>
<td>0</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Informatics</td>
<td></td>
<td>300</td>
<td></td>
<td>300</td>
<td>300</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Nursing</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Quality, Governance &amp; Pharmacy</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Service Delivery</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Therapies</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Trustwide</td>
<td>5,429</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Subtotal</strong></td>
<td><strong>6,566</strong></td>
<td><strong>1,273</strong></td>
<td><strong>1,273</strong></td>
<td><strong>5,322</strong></td>
<td><strong>1,228</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>TOTAL</strong></td>
<td><strong>9,410</strong></td>
<td><strong>4,077</strong></td>
<td><strong>11</strong></td>
<td><strong>4,088</strong></td>
<td><strong>5,322</strong></td>
<td><strong>3,031</strong></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th></th>
<th>Apr</th>
<th>May</th>
<th>Jun</th>
<th>Jul</th>
<th>Aug</th>
<th>Sep</th>
<th>Oct</th>
<th>Nov</th>
</tr>
</thead>
<tbody>
<tr>
<td>Bexley</td>
<td>6</td>
<td>8</td>
<td>17</td>
<td>22</td>
<td>26</td>
<td>19</td>
<td>20</td>
<td>29</td>
</tr>
<tr>
<td>Bromley</td>
<td>14</td>
<td>14</td>
<td>18</td>
<td>26</td>
<td>21</td>
<td>38</td>
<td>21</td>
<td>21</td>
</tr>
<tr>
<td>Greenwich</td>
<td>18</td>
<td>18</td>
<td>26</td>
<td>21</td>
<td>38</td>
<td>21</td>
<td>33</td>
<td>33</td>
</tr>
<tr>
<td>Children &amp; Y.P.</td>
<td>508</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>33</td>
</tr>
<tr>
<td>Forensic &amp; Prisons</td>
<td>10</td>
<td>10</td>
<td>13</td>
<td>10</td>
<td>39</td>
<td>44</td>
<td>44</td>
<td></td>
</tr>
<tr>
<td>Estates</td>
<td>555</td>
<td>36</td>
<td>54</td>
<td>57</td>
<td>75</td>
<td>122</td>
<td>124</td>
<td>134</td>
</tr>
<tr>
<td>Finance</td>
<td>739</td>
<td>3</td>
<td>3</td>
<td>27</td>
<td>6</td>
<td>6</td>
<td>6</td>
<td>6</td>
</tr>
<tr>
<td>HR</td>
<td>4</td>
<td>4</td>
<td>4</td>
<td>4</td>
<td>4</td>
<td>4</td>
<td>4</td>
<td>4</td>
</tr>
<tr>
<td>Informatics</td>
<td>2</td>
<td>2</td>
<td>2</td>
<td>2</td>
<td>2</td>
<td>2</td>
<td>2</td>
<td>2</td>
</tr>
<tr>
<td>Quality, Governance</td>
<td>770</td>
<td>34</td>
<td>34</td>
<td>57</td>
<td>37</td>
<td>37</td>
<td>37</td>
<td>37</td>
</tr>
<tr>
<td>Pharmacy &amp; Service</td>
<td>1,326</td>
<td>70</td>
<td>88</td>
<td>114</td>
<td>112</td>
<td>159</td>
<td>161</td>
<td>171</td>
</tr>
</tbody>
</table>

- The 19/20 target equates to £9.4m and includes any CRE not delivered recurrently in 18/19 (£4.8m)
- £4.1m now represents the latest FYE plans.
- Total value to be delivered in 19/20 equates £3.0m; creating a £6.4m pressure. Taking into account all operational underspends and unallocated reserves the majority of the non-recurrent support offsets the gap in CRE delivery.
- Monthly finance meetings and the bi-monthly CRE meetings will continue to oversee the delivery and development of these schemes on a on-going basis.
Appendix 3 - Agency Analysis

Targeted approach to teams with high agency spend remains in place with the agency taskforce regime reinstated as and when required.

The weekly agency control panel continues to review all agency requests for clinical and non-clinical. The only exception relates to inpatient nursing roles where the judgement is undertaken locally.

2019/20 - agency ceiling remained unchanged from 18/19.
The table below sets out the Acute and PICU Commissioned and Occupied bed days utilised by each borough in the month. There are varying risk shares between the BBG commissioners and table sets the overspend risk share attributable to Oxleas.

<table>
<thead>
<tr>
<th></th>
<th>CBD</th>
<th>Oxleas beds</th>
<th>ACUTE UEA</th>
<th>FEMALE PICU UEA</th>
<th>MALE PICU UEA</th>
<th>Total OBD</th>
<th>Activity var</th>
</tr>
</thead>
<tbody>
<tr>
<td>Nov</td>
<td>1,200</td>
<td>1,085</td>
<td>0</td>
<td>60</td>
<td>0</td>
<td>1,145</td>
<td>55</td>
</tr>
<tr>
<td></td>
<td>1,680</td>
<td>1,435</td>
<td>69</td>
<td>111</td>
<td>30</td>
<td>1,645</td>
<td>35</td>
</tr>
<tr>
<td></td>
<td>1,980</td>
<td>1,721</td>
<td>146</td>
<td>0</td>
<td>32</td>
<td>1,899</td>
<td>81</td>
</tr>
<tr>
<td></td>
<td>4,860</td>
<td>4,241</td>
<td>215</td>
<td>171</td>
<td>62</td>
<td>4,689</td>
<td>171</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th></th>
<th>Budget £k</th>
<th>Actual £k</th>
<th>Over spend £k</th>
<th>Oxleas Share</th>
</tr>
</thead>
<tbody>
<tr>
<td>Nov</td>
<td>28,684</td>
<td>48,824</td>
<td>-20,139</td>
<td>-7,324</td>
</tr>
<tr>
<td></td>
<td>42,364</td>
<td>144,166</td>
<td>-101,802</td>
<td>74,871</td>
</tr>
<tr>
<td></td>
<td>114,167</td>
<td>119,815</td>
<td>-5,648</td>
<td>-33,206</td>
</tr>
<tr>
<td></td>
<td>185,215</td>
<td>312,805</td>
<td>127,589</td>
<td>34,342</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th></th>
<th>CBD</th>
<th>Oxleas beds</th>
<th>ACUTE UEA</th>
<th>FEMALE PICU UEA</th>
<th>MALE PICU UEA</th>
<th>Total OBD</th>
<th>Activity var</th>
</tr>
</thead>
<tbody>
<tr>
<td>YTD</td>
<td>9,760</td>
<td>8,268</td>
<td>342</td>
<td>252</td>
<td>171</td>
<td>9,033</td>
<td>727</td>
</tr>
<tr>
<td></td>
<td>13,664</td>
<td>11,550</td>
<td>480</td>
<td>758</td>
<td>146</td>
<td>12,934</td>
<td>730</td>
</tr>
<tr>
<td></td>
<td>16,104</td>
<td>16,018</td>
<td>1,256</td>
<td>0</td>
<td>329</td>
<td>17,603</td>
<td>-1,499</td>
</tr>
<tr>
<td></td>
<td>39,528</td>
<td>35,836</td>
<td>2,078</td>
<td>1,010</td>
<td>646</td>
<td>39,570</td>
<td>-42</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th></th>
<th>Budget £k</th>
<th>Actual £k</th>
<th>Over spend £k</th>
<th>Oxleas Share</th>
</tr>
</thead>
<tbody>
<tr>
<td>YTD</td>
<td>229,473</td>
<td>614,150</td>
<td>-384,678</td>
<td>201,410</td>
</tr>
<tr>
<td></td>
<td>338,915</td>
<td>684,621</td>
<td>-345,706</td>
<td>205,852</td>
</tr>
<tr>
<td></td>
<td>913,333</td>
<td>1,179,669</td>
<td>-266,336</td>
<td>266,336</td>
</tr>
<tr>
<td></td>
<td>1,481,721</td>
<td>2,478,441</td>
<td>996,719</td>
<td>673,597</td>
</tr>
</tbody>
</table>
Report Title | Infrastructure Committee Minutes (Meeting 17 December 2019)
Author | 
Accountable Director | Rachel Evans - Director of Estates & Facilities
Confidentiality/FOI status | 

Report Summary | Capital Programme

- Expenditure on the 2019/20 capital plan has reduced to £16.8m from £17.7m mainly due to the delay in the QMH theatres project.
- The 5 year plan indicates expenditure of £2m in future years for IT whereas the requirement in 2020/21 alone is £4m. It was agreed that as there is a gap between the digital expectations and the proposed spend for IT, this should be drawn to the attention of the Board; and the Executive’s Team review of the 2020/21 capital programme should include for a realistic view on the future investment needs for digital technology to be taken.
- The 2020/21 programme is being drafted and it is anticipated that it will be presented to the next Board meeting.

Property Disposals

- It was agreed that no further property sales would take place this financial year.

Estates Report

- The Penge CMHC successfully moved from Yeoman House to Beckenham Beacon on 17/18 December. The CCG has advised that the additional estates costs between the two properties will be funded through MHIS monies.
- Significant progress has been made in mitigating the void costs of the Greenwich Startwell contract leaving a residual pressure of £132,000. This mainly relates to Wallace Health Centre which is difficult to backfill due to its location.
- A review of estate focussing on Memorial Hospital is being undertaken due to recent changes in services (ie Wheelchair and Startwell).
- An extension of the hard FM contract is being considered to allow time for the existing contractor to respond to complaints and improve delivery.

Queen Mary’s Hospital

- Phase 2 works are complete and well received. An open event has taken place.
- A new M&E consultant has been appointed to the QMH theatres project. Once the new design is complete, GallifordTry will be asked to re-cost the scheme but if necessary it will be tendered to the open market to ensure value for money.

**IT Report**
- The launch of e-obs continues to be delayed but the contractor has committed to finding a solution by the end of December.
- The Dr Julian pilot is being extended.

**Digital Strategy**
- The Committee was impressed with the strategy and agreed the priorities. There was discussion about how the digital strategy could support staff wellbeing and that the implications around training and education for staff and patients in the future need to be considered.

**Risk Register**
- Risk 1695 - Patients and staff at Greenwich Square may be compromised because we are operating out of a building where fire safety improvements are required, and the Trust has not received statutory compliance information from NHS Property Services. The Head of Safety & Compliance will produce a report for the Executives to consider whether we vacate the property.

### Purpose

<table>
<thead>
<tr>
<th>(To select purpose, click on relevant choice for drop down box)</th>
<th>Information</th>
<th>To Note</th>
<th>√</th>
</tr>
</thead>
<tbody>
<tr>
<td>Approval</td>
<td>Decison</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

### Recommendation
- The Board is asked to note the updates from the Infrastructure Committee.

### Link to strategic objectives click on relevant choice for drop down box
- Quality √
- Workforce
- Sustainability √
- Partnerships √
<table>
<thead>
<tr>
<th>Quality</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Financial</td>
<td>Financial implications are discussed in the report.</td>
</tr>
<tr>
<td>Equality analysis</td>
<td></td>
</tr>
<tr>
<td>Service user/carer/staff</td>
<td></td>
</tr>
</tbody>
</table>
### Board of Directors

#### 9 January 2020

**Report Title**  
Digital Strategy

**Author**  
Alison Furzer, Director of Informatics

**Accountable Director**  
Alison Furzer, Director of Informatics

**Confidentiality/FOI status**  
Public

#### Report Summary

Our new digital strategy has been approved by the Executive and Infrastructure Committee. The final draft is attached for agreement by the board.

#### Purpose

(To select purpose, click on relevant choice for drop down box)

- Information  
  - To Note
- Approval  
  - Decision

#### Recommendation

- Link to strategic objectives (click on relevant choice for drop down box)
  - Quality ✓  
  - Workforce ✓  
  - Sustainability ✓  
  - Partnerships ✓

- Link to Board Assurance Framework
  - N/A

#### Implications

- Quality
- Financial
- Equality analysis
- Service user/carer/staff
Our strategy builds on what we have achieved so far and reaffirms our view that the successful use of new technology will enhance and support staff to care more efficiently and effectively.

We will also focus on how we can enable our service users to take a more active role in their health and support them in doing so, particularly if they are vulnerable or unsure about using technology.

To succeed we must build on our skills as an organisation and work together to develop, test and adopt innovation.

We look forward to realising this ambition together.

Alison Furzer, Director of Informatics
James Woollard, Chief Clinical Information Officer

Introduction

The use of new technology has been identified as crucial by the NHS Long Term Plan. In time, it will impact on every aspect of care providing us with new ways to understand and treat health conditions and effectively manage and share information.

At Oxleas, we have invested significantly to build on the technology already available to us. Funding from the national Global Digital Exemplar Fast Follower Programme (GDEFF) means we have been able to accelerate this investment. As a result, we are well placed to deliver on both national and local ambitions to improve the lives of those we care for.

We’re also committed to including staff on our digital journey, providing training and education to ensure there are no barriers to using the digital technology available to us all.
B  Our priorities

- Digitally connected patients
- Improving our processes
- Right information, right time
- Digitally connected workforce
- Smarter working
- Our digital infrastructure

Our key approaches

- Co-design change with all users, keeping patients/service users at the centre
- Share learning about how to best use technology across the organisation to improve the working lives of our staff and the care we provide
- Make accurate information available in timely ways to all those who need it for improving lives in our communities
- Continuously adopt and adapt systems to support the provision of clinical care.
C Digitally connected patients

Digital technology provides an opportunity for people to take an increasingly active role in their own health and care.

Working with staff and service users, we will create and co-design digital platforms and pathways to enable people to access care in different ways, complementing our existing face-to-face opportunities.

One of these will be a digital personal health record (PHR), where clinicians can share information such as care plans, letters and leaflets with our service users. Clinician-recommended digital self-help tools will play a pivotal part in supporting people between appointments.

The provision of a digital appointment system will mean clinicians can offer services from different locations and at different times. For many of our service users, it will provide a much more convenient way of receiving care.

Digital services create opportunities for carers and other key members of our service users’ support network to, with the service user’s permission, join appointments or access patient digital records.

We recognise that not all our service users or carers will have the skills or equipment they need to engage with us in this way, so we will review regularly to ensure technology isn’t a barrier to accessing our services.

In year one we will:

- Have teams across our services booking and delivering online appointments with patients
- Have some service users accessing their care plans through the online health record
- Have carers joining therapy and inpatient ward rounds remotely using video conferencing tools
- Receive all mental health referrals electronically into the clinical system.
D Improving processes and pathways

We’ve made good progress in introducing digital tools to improve our clinical processes and pathways, digitising many clinical administrative tasks.

These include the use of:
• Connect Care
• Docman
• E-referrals
• Hybrid mail
• Digital dictation technology

Our Electronic Patient Records system (EPR) is established across the trust so staff can access clinical information via their iPads and laptops when out and about. We will build on these foundations to ensure staff have timely, electronic access to care information to support them in providing effective and efficient care.

E-obs and E-Meds will be introduced which will greatly reduce paperwork and administrative burdens on our wards. They will provide digital data which can be easily reviewed and used to support improved patient outcomes.

Valuable clinic time will be freed up by the use of systems which allow patient information to be shared with clinicians ahead of appointments. Patients will not have to repeat themselves and clinicians can focus on diagnosis and treatment.

Improvements to our clinical systems will aid clinicians in recording high-quality data needed to care for patients. The use of increasingly intelligent computer software will also assist with clinical decision making and analysis of medical images.

We will continue to work with the South London Partnership (SLP) trusts and Integrated Care Systems to develop processes which allow information to be shared with our broader clinical workforce.

We’ll also work to develop new solutions to improve the management of patient pathways on our wards and in the community. Patients who can interact with our services digitally will help shape how these evolve. Any digitally-enabled changes will always be made jointly with staff and those we care for.

In year one we will:
• Roll out electronic observations across all our inpatient services
• Link the RiO diaries of clinicians with their NHS mail diary
• Trial route planning technology to help our clinicians get to their patients more quickly
• Have introduced e-Meds with electronic drug charts on our in-patient wards.
In year one we will:

• Work with staff to increase the use of key dashboards such as the clinicians tasklist.
• Introduce real-time data into some of our iFox reports to help clinicians manage their daily workload.
• Co-design team dashboards with clinicians and their managers to assist with patient care and team workload.
• Provide easy access to job planning information via a new job planning tool.

As a trust, we need accurate, timely information about the services and care that we provide. We all need the right information to be available to us, at the right time, to help us improve the quality of care we offer our service users.

Through the development of iFox, our information system, we have built a platform that enables us to share key clinical information to support clinicians to deliver better patient care.

We want to build upon this platform to increase the timeliness of information for our clinicians. For example, we will focus on providing more real-time data to support services to manage demand and capacity within our bedded (inpatient) services and community teams.

We will work closely with clinicians to identify data which demonstrates a need for change, as well as monitor the impact of any change made.

In this way we can shape services and drive improvement.

As we develop our plans, we will consider how we visualise the data that we produce, in different ways for different audiences, to ensure that we help to clearly draw attention to the data that ‘tells a story’. We will also focus on making key performance data available for clinicians, with updates in one place so it is easier to see the ‘whole picture’ of improvement.

As part of our digital workforce initiative we will set up a programme to ensure that we improve data literacy across the organisation. We will utilise our ‘digital ambassadors’ to increase confidence in the recording of high-quality data within our clinical systems, and then using that data to improve services.

£129k

Saved in 2018 on postage and stationery using Docman.

Clinicians save up to 1 hour per day by using mobile technology.

147,096

Text appointment reminders sent in last 12 months.

2,294 iPads

904 iPhones

Majority used by community clinicians.

In this way we can shape services and drive improvement.

As we develop our plans, we will consider how we visualise the data that we produce, in different ways for different audiences, to ensure that we help to clearly draw attention to the data that ‘tells a story’. We will also focus on making key performance data available for clinicians, with updates in one place so it is easier to see the ‘whole picture’ of improvement.

As part of our digital workforce initiative we will set up a programme to ensure that we improve data literacy across the organisation. We will utilise our ‘digital ambassadors’ to increase confidence in the recording of high-quality data within our clinical systems, and then using that data to improve services.
In year one we will:

- Work with colleagues to identify ‘digital ambassadors’ across the trust
- Establish a digital ambassador’s training and engagement programme
- Work with colleagues to strengthen our clinical digital leadership
- Work with service users to co-design a patient digital engagement programme.

We already have a number of digital systems in use across Oxleas and there are some great examples of the innovative use of technology by clinicians within our services.

To achieve the Long Term Plan ambition of a ‘digital first’ option for most, we recognise that staff need both the skills and confidence to use technology to provide ‘people-first, digitally-enabled’ care.

Digital change is accelerating across the NHS, so we must ensure that all of our staff develop the skills to provide health and care in an increasingly technology driven world.

We will work closely with colleagues across the trust, and externally, to identify how we can deliver the programme, linking into national initiatives like the RCN’s ‘every nurse an e-nurse’, and being guided by recommendations from the Topol review.

The programme will have specific aims supported by training materials, digital communications and face to face events. There will be partner programmes focussed on creating RiO champions and iFox data resources.

If staff are confident with technology they will naturally instil confidence in our patients to engage with new models of care. By routinely asking our service users about their digital skills we can empower them to book digital appointments and access their records online.

We do recognise that some service users will not always have access to the equipment they need to use digital services. Planning how we support and signpost service users to equipment, either within our services or available within the wider community, will be an important element of our digital inclusion programme.

To borrow a phrase, ‘no one will get left behind’ as we continue to improve the lives of our staff, patients and communities.
In year one we will:

- Work with services to ‘test and learn’ different IT equipment for different users to see what works well.
- Work with clinicians and admin staff to identify different IT equipment offerings for different roles.
- Work with Estates and HR colleagues to develop a ‘Smarter ways of working’ policy.
- Automate our new user processes so that new staff have immediate access to email and the trust network.

G Supporting smarter ways of working

We want to embrace the opportunities that technology offers to create a workforce that can ‘work from anywhere’. Whilst these opportunities may be more suited to some of our clinical services, technology offers us all the opportunity to think how we could work differently in the future.

We have made good progress with the adoption of mobile working in many teams over the last few years. We now have an opportunity to evaluate the technology already in place and what best suits the needs of our clinicians in the future. We want to ensure that we equip all staff with the right tools to do their jobs, along with the right infrastructure to support them.

We have already surveyed staff to get a wide range of views on how we could use technology to help them work differently. What is evident is that there are many opportunities to provide care in different ways and for staff to work in more flexible ways.

We also acknowledge that working differently is not just about the IT equipment we provide. We will also need to support staff to think differently about how they may work in the future.

We will be testing out our approach to smarter ways of working with teams in different areas of the trust, understanding how their cultures and practices personalise their needs. This will help inform our approach as we consider broader digital adoption.
Building on our digital infrastructure

Our digital infrastructure provides the foundations to deliver our digital strategy. We recognise that our digital services add the most value when they are readily available to our staff who use them to deliver high quality healthcare.

We will continue to invest in our infrastructure to ensure that it is robust, secure and has the capacity to meet the needs of our expanding ambition.

Most importantly, we will continue to invest in cybersecurity technology, so that the information we store digitally remains safe and secure.

To deliver the goals within the strategy we will need to ensure that the current technology supporting services is well maintained and remains fit for purpose.

We will also need to consider what additional supporting infrastructure technology is required as we grow our digital plans.

A key part of our future plans will be to ensure that our systems use open standards so we can share electronic information easily with relevant partners and other providers of health care.

As well as insuring investment in our core infrastructure we will also consider how we utilise technology so that we improve the new user experience, facilitate easier access to systems and ensure our IT helpdesk remains as efficient as possible.

£5m invested in new technology in last two years

In year one we will:

• Replace our oldest IT equipment as part of our replacement program (laptops and iPads)
• Be a Cybersecurity Essential Plus accredited organisation
• Invest in new storage and server hardware to maximise the performance and longevity of our infrastructure
• Implement technology to semi-automate the distribution of security updates ensuring they are deployed more quickly and efficiently.

£5m invested in new technology in last two years

In year one we will:

• Replace our oldest IT equipment as part of our replacement program (laptops and iPads)
• Be a Cybersecurity Essential Plus accredited organisation
• Invest in new storage and server hardware to maximise the performance and longevity of our infrastructure
• Implement technology to semi-automate the distribution of security updates ensuring they are deployed more quickly and efficiently.
Sarah is a therapist. She has a son and daughter aged 8 and 4 and works three days a week. She would like to increase her hours but would struggle with childcare arrangements so she is looking at other roles to find a way to work more.

The Improving Access to Psychological Therapies (IAPT) service where Sarah works has a long waiting list. She knows that many of her patients would benefit from seeing a therapist more quickly, but find it difficult to attend appointments during the day because of their own work commitments.

Sarah has spoken to her manager about how patients would benefit from being offered appointments outside of the traditional Monday to Friday, 9am to 5pm. She knows that some teams are offering online video appointments and would like to be able to do the same.

Sarah agrees with her manager to work an additional 6 hours a week at home offering video appointments on two evenings between 6pm and 9pm. She receives the support and training she needs to be able to confidently use the equipment needed to make contact with patients online.

As a result of this change, patient feedback improves, waiting times are reduced and colleagues of Sarah show an interest in also working outside of normal hours. Sarah is happier and no longer looking for another job. Her manager knows that as well as supporting one of her key members of staff, patient experience has improved and she no longer needs to worry about Sarah leaving the team.

Our digital future - in five years

I can see my clinician via an online appointment, so I don’t have to travel to some appointments.

I can tell my story once, and know that my information will follow me around the trust and beyond.

Right information, right time

I am meeting with my patients using online appointments, reducing travel time and freeing up time to care.

I am able to share a range of tailored information to my patients via their personal health record.

My test results are available online.

Improving our processes

Improving our processes

I am able to share a range of tailored information to my patients via their personal health record.

Improving our processes

My test results are available online.

Improving our processes

I can tell my story once, and know that my information will follow me around the trust and beyond.

As a team manager, I will have real-time information about how well my service is doing so that I can ensure the team’s goals are met on a day-to-day basis.

Digitally connected patients
Michael is 34 and has long-term mental health issues. He often has trouble adhering to his medicine regime and is on an inpatient ward after attending A&E in crisis.

Michael lives at home with his parents, who both work full time but want to support him during his stay. They would like to be part of discussions about how they can best help their son, but find it difficult to visit during the day.

A multi-disciplinary team meeting (MDT) is arranged as Michael is keen to be discharged with additional help to improve his medication adherence. His parents, who have access to Michael's online health records as his carers, are able to join the meeting via a video link.

Michael's assigned nurse works with him for the next two weeks, using the iPad that his observations are collected on, to find new ways to support him in developing his living skills and coping strategies for improved independence. Together they agree on an app to track realistic goals and find a walking club to join.

Michael is discharged and keeps in regular contact with his care co-ordinator using video appointments which are convenient and mean he doesn't have to travel. The video appointment allows his care co-ordinator to also see Michael which helps with assessing his mental state.

This extra online support helps Michael feel more independent and makes it easier for him to adhere to his medication regime.

---

**Our digital future - in five years**

**Digitally connected workforce**

- I can get support and advice about what digital tools will support my self-care.
- I will be able to recommend to my patients digital tools which will support them with their self-care.
- I have access to the right equipment for my role so that I can do my job effectively.
- I can use tablet devices with staff to support me during my appointment or when preparing for discharge.
- I have access to all the appropriate clinical and corporate systems for my role when I am out in the community or at home.
- I am confident with the digital tools available to me.
Contact us

Informatics Directorate
Pinewood House
Pinewood Place
Dartford
Kent DA2 7WG

01322 621016
Report Summary

The Workforce Committee met on 20th November 2019

Workforce summary report and KPIs

The committee received updates on various programmes of work being undertaken across the trust to support delivery against the workforce and equality strategies. This included a number of initiatives implemented to support delivery against the Workforce Race Equality Standard (WRES) and Workforce Disability Equality Standard (WDES) Trust Action Plans supporting “a fair experience for all”. An area of particular focus is on the WRES 3 indicator because the proportion of BME staff entering disciplinary processes in the trust is much higher than we would want.

Updates were provided on the extensive work happening to improve retention and the committee requested more detailed feedback from the trends being seen from the one year on and leavers’ surveys to be shared in the future.

The committee debated a new relationship policy and suggested a couple of tweaks to the wording prior to launching across the Trust. This will be finalised ready to roll out in quarter 4.

The committee reviewed the workforce KPIs, all of which were on target within the normal ranges seen at this time of the year but work with the directorate teams will start through quarter 4 to ensure the KPIs being produced, and format of the information provided outside of the workforce team is relevant and user friendly to enable managers to have the accountability for their own performance. The committee asked for more support to managers to ensure prioritisation is given to roster finalisation as the figures had dropped slightly this month and we do not want to lose the focus and hard work that the team went through to achieve 100% compliance. Work is also planned to tackle longer-term sickness absence and to identify those teams where sickness levels are high, with a view to identifying whether additional interventions are required.

Improving our Disciplinary Process and Practices

The committee reviewed the current disciplinary process and practices within the Trust and for the first time the 11 cases that the Trust is currently managing as per the recommendations shared by NSHI/E. This information will be shared quarterly moving
forward. The findings show that a large proportion of the current cases are over the policy stated 56 days to complete the process. The committee discussed the recent innovations to the process, including introduction of a “commissioning manager” role who would play a key part in moving cases forward. It was suggested that the definition and responsibilities of commissioning managers are clearly defined in the policy and explained at the outset of the case.

The committee asked if we could benchmark the information provided by Oxleas to the Board against other organisations to ensure that we are achieving the right levels of oversight. Having spoken to our sister Trusts, it appears that all are sharing a similar level of data but we will keep this under review.

**Corporate Welcome**

Changes to the way the corporate welcome is being booked were noted and it was observed that the changes appeared to have resulted in improved attendance levels on the day. The committee asked that the team to continue to monitor the number of people who should be attending the corporate welcome, to ensure that numbers are suitably high and remains a priority for new-joiners.

**Medical Workforce Update**

The medical workforce update paper was well-received and the committee recognised the important work happening across the Trust to support doctors’ workload pressures. The head of medical staffing attended to answer further questions and the committee heard how the initiatives put into place were having a positive impact. The feedback from the GMC annual survey was discussed and it was explained to the committee that the new cohort of trainees who joined the trust in August 2019 appeared to have a different set of concerns to their predecessors and so the initiatives in place would be kept under review. Further monitoring and close working between all parties will ensure feedback received is acted upon.

An in-depth look into the current vacancy levels and use of agency workers was helpful to put some of the GMC feedback received into perspective.

It was agreed that this level of detail will then be shared on a six-monthly basis to the committee as a rolling agenda item. It was also agreed that any surveys that might exist for other staff groups should also be scrutinised and discussed at the workforce committee.

**Freedom to Speak Up (FTSU) Six Monthly Report**

The latest results from the last six months were shared. These showed an increase in number of cases received through 2019-2020 compared to 2018-2019. The committee asked for more information in the future about the actions taken in response to the themes raised. It also asked to see the number of cases being raised through the FTSU guardians that might have been better raised via a different route. The Guardian Service will provide this level of detailed analysis and insight moving forward.
**Risk Register**

The latest risk register was reviewed with no immediate changes being made to current risks and ratings. It was agreed that the risk register would be reviewed by the incoming Strategy and People Director and recommendations brought to the next meeting.

**Health and Safety Update**

No serious staff incidents had been reported since the previous workforce committee meeting.

Following submission of Trust emergency planning assurance documentation on 3rd September 2019, our annual assurance visit took place on 15th October 2019. This was attended by representatives from NHSE & I, and Bexley CCG, with a peer reviewer from South London and Maudsley NHSFT. The assessment was against 69 core standards and 20 new deep dive standards, which were focused primarily on climate change. The Trust was found to be ‘Fully Compliant’ on all core standards and all deep dive standards. This is the second year that we have achieved fully compliant status and the Trust was again commended on several areas of good practice.

The Health and Safety Strategy was presented and agreed that this is the responsibility of everyone in the organisation, something that is not always recognised.

Further conversations need to continue around the governance arrangements with oversight remaining within the Workforce Committee for the time being.

<table>
<thead>
<tr>
<th>Purpose (To select purpose, click on relevant choice for drop down box)</th>
<th>Information ✓ To Note ✓</th>
</tr>
</thead>
<tbody>
<tr>
<td>Approval</td>
<td>Decision</td>
</tr>
</tbody>
</table>

**Recommendation**

The Board is asked to note the report.

<table>
<thead>
<tr>
<th>Link to strategic objectives (click on relevant choice for drop down box)</th>
<th>Quality ✓ Workforce ✓ Sustainability Partnerships ✓</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Link to Board Assurance Framework</th>
</tr>
</thead>
<tbody>
<tr>
<td>- 1213 - Recruitment</td>
</tr>
<tr>
<td>- 1471 – Violence, Bullying and Discrimination</td>
</tr>
<tr>
<td>- 1502 – Retention and staff satisfaction</td>
</tr>
</tbody>
</table>

**Implications**

*Briefly outline implications of the recommendations in this report*
<table>
<thead>
<tr>
<th>Quality</th>
<th>It is recognised that a full, competent and engaged workforce is needed to support excellent quality of care.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Financial</td>
<td>The financial implications of temporary staff are considered.</td>
</tr>
<tr>
<td>Equality analysis</td>
<td>The Workforce Committee programmes of action aim to tackle inequality issues.</td>
</tr>
<tr>
<td>Service user/carer/staff</td>
<td>The strategy development programme will increase engagement with service users, carers and staff</td>
</tr>
</tbody>
</table>
# Board of Directors

9 January 2020

<table>
<thead>
<tr>
<th>Item</th>
<th>16</th>
</tr>
</thead>
<tbody>
<tr>
<td>Enclosure</td>
<td>16</td>
</tr>
</tbody>
</table>

## Report Title
Freedom To Speak Up – Yearly Report

## Author
Wendy Lyon, Head of Staff Partnership

## Accountable Director
Rachel Clare Evans, Director of Strategy and People

## Confidentiality/FOI status
Public

## Report Summary
Information on the uptake of staff speaking up during 2019

## Purpose
(To select purpose, click on relevant choice for drop down box)
- Information
- Approval

## Recommendation
The Board agrees the minutes as a true record of the meeting.

## Link to strategic objectives
(Click on relevant choice for drop down box)
- Quality
- Workforce
- Sustainability
- Partnerships

## Link to Board Assurance Framework
- 1213 - Recruitment
- 1471 – Violence, Bullying and Discrimination
- 1502 – Retention and staff satisfaction

## Implications

| Quality | High quality patient care requires a culture where staff feel able to speak up about important and difficult issues, including patient experience. |
| Financial | Staff who feel disengaged and unheard are more likely to leave the organisation, creating financial pressures. |
| Equality analysis | A culture where all staff feel able to speak up will benefit staff of all protected characteristics. |
| Service user/carer/staff | The FTSU work has a predominantly staff focus, but other avenues are in place to ensure that service users and carers can raise concerns. |
1. **Introduction**

This report provides an update on how the Freedom to Speak-Up (FTSU) process has been used over the past 12 months, the types of concerns raised and how they have been addressed. The FTSU process has been managed until December 2019 by the Staff Partnership team and is now being taken forward by the Guardian Service – an external company.

2. **12-month update (March 2019 – December 2019)**

The efforts to increase the volume of cases over the last year have been successful. The Trust had some 78 issues raised over 2019 as compared with 19 cases between March and December in 2018. Some of the concerns were raised through the portal and others during staff feedback sessions. The staff feedback sessions have been a good source of local information and have provided a means of capturing additional areas of concern. The ‘SpeakinConfidence’ portal appears to have been successful in helping staff to feel that they could report their concerns in confidence and obtain a quick response.

<table>
<thead>
<tr>
<th>Method of Reporting</th>
<th>2018</th>
<th>2019</th>
</tr>
</thead>
<tbody>
<tr>
<td>Directly through the Portal</td>
<td>-</td>
<td>51</td>
</tr>
<tr>
<td>Through the Staff Feedback Sessions</td>
<td>2</td>
<td>22</td>
</tr>
<tr>
<td>Directly to one of the guardians.</td>
<td>7</td>
<td>1</td>
</tr>
<tr>
<td>Anonymously</td>
<td>1</td>
<td>0</td>
</tr>
<tr>
<td>CQC</td>
<td>6</td>
<td>0</td>
</tr>
<tr>
<td>Senior Independent Director</td>
<td>2</td>
<td>1</td>
</tr>
<tr>
<td>CEO</td>
<td>1</td>
<td></td>
</tr>
<tr>
<td>Emails</td>
<td>0</td>
<td>2</td>
</tr>
<tr>
<td>Other</td>
<td>1</td>
<td></td>
</tr>
<tr>
<td><strong>TOTAL</strong></td>
<td><strong>19</strong></td>
<td><strong>78</strong></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Directorate</th>
<th>Employee known</th>
<th>Raised anonymously</th>
<th>Total</th>
<th>Employee known</th>
<th>Raised anonymously</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>ALD</td>
<td>1</td>
<td>1</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Bexley</td>
<td>2</td>
<td>2</td>
<td>3</td>
<td>6</td>
<td>9</td>
<td>15</td>
</tr>
<tr>
<td>Bromley</td>
<td></td>
<td></td>
<td>2</td>
<td>11</td>
<td>13</td>
<td></td>
</tr>
<tr>
<td>Corporate</td>
<td>1</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>8</td>
<td>10</td>
</tr>
<tr>
<td>CYP</td>
<td>1</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>22</td>
<td>24</td>
</tr>
<tr>
<td>Prisons &amp; Forensics</td>
<td>1</td>
<td>4</td>
<td>5</td>
<td>0</td>
<td>4</td>
<td>4</td>
</tr>
<tr>
<td>Greenwich</td>
<td>1</td>
<td>4</td>
<td>5</td>
<td>2</td>
<td>10</td>
<td>12</td>
</tr>
<tr>
<td>Unknown</td>
<td>4</td>
<td>4</td>
<td>4</td>
<td>6</td>
<td>6</td>
<td>6</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>4</strong></td>
<td><strong>15</strong></td>
<td><strong>19</strong></td>
<td><strong>11</strong></td>
<td><strong>67</strong></td>
<td><strong>78</strong></td>
</tr>
</tbody>
</table>
Assessment of Cases

Each concern raised is captured in a log which includes the nature of the issue, the action taken and the follow-up. The cases that are raised are fairly diverse and low-level in nature.

There are quite a number of cases that relate to bullying and harassment and it will be important for the trust’s work in this area to continue, including monitoring the forthcoming staff survey results. There are some cases which have a tangential impact on patient safety and wellbeing e.g. no heating in a particular building or poor supervision, but there are very few cases that directly relate to patient safety.

Going forward, the Guardian Service will report to the Board on the themes being raised by staff. Further information is provided on this below.

Actions taken in response to concerns raised

Actions are taken promptly to address areas of concern raised through both the portal and the staff feedback sessions.

Cases raised through the portal have been allocated directly to the responsible Director who is personally responsible for providing a quick response and undertaking further investigations, where appropriate. Most cases have been dealt with by the Director of Nursing and the previous Director of Workforce and OD. The responsible Directors have also been well-placed and responsible for identifying any themes that arise and any wider learning that may need to be embedded, particularly in relation to any possible impact on patient safety. We ask local leaders to ensure that answers that may be of more general interest are communicated more widely to relevant staff.

Concerns that are raised in a Staff Feedback Session form part of a report that highlights both the good practice as well as the concerns raised. These reports contain useful and detailed information – the full and confidential version of the report is sent to the Service Director, the Chief Executive, the Strategy and People Director and also the responsible HR Manager. A higher-level version of the report is sent to all relevant staff. The Service Director is responsible for taking forward the actions.

It appears that many of the concerns raised could effectively have been dealt with at local level, suggesting that there remains more work to do to create a culture where people feel fully comfortable raising issues of concern. Where there have been pockets of similar concerns raised in a particular area, the Staff Feedback sessions have proven an effective way of understanding more about the concerns and introducing new measures.

Improvements to our FTSU processes

The trust has been keen to identify new and improved ways of listening to staff and providing avenues for them to raise concerns. It was recognised that some staff may, for whatever reason, feel less comfortable pursuing their concerns through internal channels. As a result, we have commissioned a completely independent service. This should help reinforce the independent nature of the Freedom to Speak Up process and to provide further confidence to staff that their concerns will be listened to and, where appropriate, acted upon.

The new Guardian Service will be available 24 hours a day, either by telephone or email. Once the staff member has made contact, the Guardian may offer to meet with the person face to face and an
appointment will then be set up at one of our sites. The Guardian Service will provide regular reports on the uptake and themes and will attend the Executive and the Board, as required.

There has been considerable focus on raising the visibility of the FTSU process. There has been a communications campaign around the launch of the new service, involving stories on the Ox, widely distributed posters and more. Teams have been visited in person to raise the profile of the new Guardian Service and further meetings are being scheduled throughout the New Year to continue to raise the profile and allow staff to ask any questions they may have about the new service.

Going forward, the new Guardian Service will bring to the Board an analysis of trends, including whether the number of cases is increasing or decreasing, any themes in the issues being raised (such as types of issue, particular groups of workers who speak up, areas in the trust where issues are being raised more or less frequently than might be expected), and information on the characteristics of people speaking up. They will also bring information about what the trust has learnt and what improvements have been made because of workers speaking up.

**General reflections from the outgoing FTSU guardians**

The outgoing guardians were invited to reflect on the areas that need continued focus for the future. They highlighted the following points:

1. **Feedback to staff needs to be prompt:** Whatever format is used, staff need a timely and robust response. When they have used the portal, staff have usually received a response within 48 hours – quite often on the same day. The Guardian Service will also operate to specified timescales and a quick turnaround. However, more work needs to be done to ensure that the follow-up to the Staff Feedback sessions is as prompt as the other channels. Delays undermine staff confidence in the system and potentially discourage participation.

2. **Most of the concerns raised were suitable for raising locally rather than centrally.** More needs to be done to create a culture where staff feel consistently able to speak up. This needs to be embedded in the training and development for our managers as well as increasing the opportunities for staff to express their views – e.g. through the strategy development process, the staff assemblies etc. The Guardian service will also encourage staff to raise their concerns locally, if they feel able to do so.

3. **The new system will rely on either telephone calls or contact by email.** Unlike the previous system, there is no scope for concerns to be raised wholly anonymously (e.g. by using an anonymous email address). That said, the Guardian Service will not share the information about staff identity with the Trust unless permission has been given by the member of staff. The trust will need to keep under review that this does not deter appropriate concerns from being raised.

3. **Conclusion**

The report summarises the activity over the last 12 months and provides information about how the new arrangements with The Guardian Service will operate. The Board will be kept updated on progress on a six-monthly basis.

The Director of Strategy and People would like to thank the outgoing FTSU guardians for their hard work in this role.
The Audit and Risk Assurance Committee last met on 19 November 2019 and highlights from the meeting are given below. The next meeting is on 21 January 2020.

**KPMG internal audit reports – core financial systems**
The audit focused on core financial systems for charitable funds and received an outcome of significant assurance with minor opportunities for improvement. Three medium priority recommendations were made relating to a strategic review of the charitable funds; spending plans; and the inclusion of charitable fund signatories on the Authorised Signatory Matrix (ASM). It was noted that there should be further clarity on the timescales for spending funds, and that there are opportunities to work with staff assemblies to take this forward.

**Local Counter-fraud Specialist Report**
The committee received assurance that the LCFS has followed up with the Oxleas HR team to ensure that reactive referrals are being captured; at previous meetings, the committee had questioned whether the low number of reactive referrals should be an area of concern. This will continue on a quarterly basis. The committee noted the actions being taken to raise awareness of the counter-fraud function.

**External auditors approach to the value for money conclusion**
The committee received a report on the external auditors approach to the value for money (VFM) conclusion. The purpose of this is to ensure that the examination of economy, efficiency and effectiveness includes non-financial risks as well as financial risks. The review focuses on the quality of the decision making. It was noted that whilst the external auditor has a duty to consider this, it is common for there not to be specific areas of focus. It was noted that Grant Thornton are currently undertaking the risk assessment as part of the audit planning process, and should be in a position to present an initial view to the Audit and Risk Assurance Committee in January 2020 for further discussion.

**Fit and Proper Persons Test**
The committee received an overview of the processes for ensuring compliance with the Fit and Proper Persons Test (FPPT). The same test applies to board directors and senior managers. Guidance is provided centrally, but there is discretion as to how this can be applied. The full FPPT is not undertaken for governors, but DBS checks are undertaken for all new appointments and re-appointments, as governors carry out site visits. It was agreed that that the FPPT for NEDs did not need to be repeated annually, but would continue to be repeated for the re-appointment of existing NEDs.

**Freedom to Speak Up**
The committee received an overview of Freedom to Speak Up (FTSU) arrangements. There has been an increase in the number of issues raised. This should be seen as a positive indicator that staff are aware of the process and have confidence in using it. Themes are reported to the Workforce Committee and will also inform our strategy development work. In December 2019, the trust moved to an independent service and a communications programme is in place to raise awareness of this.
**Risk register report from the Business Committee**
The committee received the risk register report from the Business Committee. There are currently five live risks, three tolerated risks and 12 closed risks. Emerging risks include the impact of *Flowers and others v East of England Ambulance Trust* on calculating holiday pay; the future funding of employer pension contributions; and operating a year-on-year income and expenditure position with an underlying deficit. The committee noted the on-going risks related to bids and the challenges with local authority commissioning.

**Thematic risk report – developing a risk appetite framework**
The board received a proposal for developing a risk appetite framework for the trust. Risk appetite is an expression of the amount and type of risk that an organisation is prepared to take, and risk tolerance is the boundaries of risk outside of which we do not wish to go. It was noted that the trust already applies the principles in a number of ways such as CRE QIAs and safe staffing levels, but our approach is not formally articulated. The process and timescales as summarised below were agreed by the committee.

<table>
<thead>
<tr>
<th>Item</th>
<th>Timescale</th>
</tr>
</thead>
<tbody>
<tr>
<td>Board awayday - setting the direction</td>
<td>February 2020</td>
</tr>
<tr>
<td>Detailed development work</td>
<td>February to April 2020</td>
</tr>
<tr>
<td>Draft risk appetite framework to Audit and Risk Assurance Committee</td>
<td>May 2020</td>
</tr>
<tr>
<td>Approval at Board of Directors</td>
<td>July 2020</td>
</tr>
<tr>
<td>Dissemination and implementation</td>
<td>July 2020 to July 2021</td>
</tr>
</tbody>
</table>

**Board Assurance Framework**
A summary of changes to the Board Assurance Framework is covered under a separate item.

**Purpose**
(To select purpose, click on relevant choice for drop down box)

- Information: To Note  ✓
- Approval: Decision

**Recommendation**
For the Board of Directors to note the report.

**Link to strategic objectives click on relevant choice for drop down box**

- Quality  ✓
- Workforce  ✓
- Sustainability  ✓
- Partnerships  ✓

**Link to Board Assurance Framework**
The Board Assurance Framework update is covered under a separate agenda item.

**Implications**

<p>| Quality | The report includes an update on risks relating to quality. |
| Financial | The report includes an update on risks relating to finance. |
| Equality analysis |  |
| Service user/carer/staff | The report includes an update on risks relating to workforce. |</p>
<table>
<thead>
<tr>
<th><strong>Board of Directors</strong></th>
<th>9 January 2020</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Item</strong></td>
<td>18</td>
</tr>
<tr>
<td><strong>Enclosure</strong></td>
<td>18</td>
</tr>
</tbody>
</table>

**Report Title** | NED report – Board visits  
**Author** | Various  
**Accountable Director** | Andy Trotter, Chair  
**Confidentiality/FOI status** | Public

**Report Summary**  
Several visits have been undertaken by Board members over the past month and the attached summarises the visits and outcomes. An action log is maintained of the issues raised and is monitored by Service Directors.

**Purpose**  
(To select purpose, click on relevant choice for drop down box)  
- Information  
- Approval

**To Note**  
√

**Recommendation**  
The Board is asked to note.

**Link to strategic objectives** (click on relevant choice for drop down box)  
- Quality √  
- Workforce √  
- Sustainability √  
- Partnerships √

**Link to Board Assurance Framework**  
The visits focus on risks around workforce, safety and sustainability.
Template for Non-Executive Directors’ board visits

<table>
<thead>
<tr>
<th>Date of Visit</th>
<th>Service</th>
<th>Attendees</th>
</tr>
</thead>
<tbody>
<tr>
<td>30 October 2019</td>
<td>Complaints, PALS and Patient Experience Team (Pinewood)</td>
<td>Jo Stimpson</td>
</tr>
</tbody>
</table>

**Brief description of service**

The Complaints team handle written complaints received by the Trust. They also receive verbal complaints that they ask to be put in writing.

The PALS team mainly field telephone calls and emails, dealing with current issues experienced by Service Users and their families.

The Patient Experience team encourage the use of patient experience surveys and collate results, analysing date and identifying hotspots.

**Outstanding issues from previous visit:**

There were no known outstanding issues from previous visits.

**Overview of visit**

The Complaints and PALS teams are co-located in one office, and consist of 7 people (3x PALS, 3 Complaints, 1 Manager) They are a very experienced team, with most members having long service in the trust.

Complaint volumes are reasonably static, although have shown increases recently, and the team are proud of the responses they give and that very few cases are picked up by the Ombudsman. Greenwich is flagged as a hotspot for complaints and slow response but they are positive about how they are working with the Directorate to improve response speed.

The PALS team covers the whole of the QMH site, picking up non-Oxleas services in addition to our own. The team feel they liaise well with other teams in the trust, and with other trusts. They feel they have a key role in signposting Service Users to other services and information provision, and generally feel they are kept up to date with changes. There are natural synergies between the teams and they work well together.
There were no issues identified by the Complaints and PALs teams

The Patient Experience team consists of 3 people. They are positive about the use of Smart Survey, with response rates having increased from about 2% at the introduction of the survey tool to around 9% currently vs a target of 10%. They struggle with engagement with teams and feel that capturing Service User Experience should be seen as more important. They asked the Board for more help in this.

They have also been piloting a more in-depth, qualitative Service Experience evaluation which brings many positives but is more time-sensitive.

Actions will be reviewed regularly by service directors and board visits action tracker which will be reviewed at Board every six months

<table>
<thead>
<tr>
<th>Issues raised</th>
<th>Action</th>
<th>Assigned To</th>
<th>Deadline</th>
</tr>
</thead>
<tbody>
<tr>
<td>Lack of priority given to patient experience by teams</td>
<td>Highlight the importance of obtaining patient experience feedback</td>
<td>Directors</td>
<td>Ongoing</td>
</tr>
</tbody>
</table>
Template for Non-Executive Directors’ board visits

<table>
<thead>
<tr>
<th>Date of visit</th>
<th>Service</th>
<th>Attendees</th>
</tr>
</thead>
<tbody>
<tr>
<td>22(^{nd}) November 2019</td>
<td>Bexley Adult Community Neuro Team</td>
<td>Steve James, Non-Exec Director Jazz Thind, Exec Director</td>
</tr>
</tbody>
</table>

**Brief description of service**

Service outline:

The neurological rehabilitation team provides specialist neuro rehabilitation to patients with a confirmed neurological diagnosis, in the place most appropriate for the patient. We promote patient focused goals and on-going self-management. The neurological rehabilitation team covers the borough of Bexley and patients with a Bexley GP. We are however often asked to see patient with a Bexley GP who live just outside of the borough to ensure they receive a service.

The neurological rehabilitation team follow several pathways including:

- Early Supported Discharge (ESD) Service - patients are seen within 24hrs of discharge for hospital following a stroke if they meet certain criteria.
- New Stroke Support Discharge pathway – New stroke patients being discharge from hospital.
- Supported Discharge pathway – patients with a neurological condition who are being discharge for hospital.
- Long term neurological conditions pathway – patients who have a long term condition that are being supported to manage in the community.
- Team condition specific pathways for Motor neuron disease, Parkinson and Multiple Sclerosis.

All referrals are triaged daily by a qualified clinician. Patients receive a telephone risk assessment to determine which pathway they should be placed under, and the urgency required for safety. ESD patients have a target of 24 hours.

Clinical therapy establishment is set at 21.7 wte, of which 17.9 is qualified therapists plus 3.8 unqualified assistants. In addition to this we have 3.8 admin staff. However, due to sickness and vacancies over the last year the clinical staffing levels have been: June -13.2 wte, Sept-13.8 wte, Nov-12.3 wte.

As well as the number of referrals, and the speed required for them to be assessed, it has been noted that the complexity of the patients has increased over the years. Similarly, patients are being discharged from acute Trusts earlier than previously (due to bed pressures), which often means there has been no discharge planning from a therapy perspective – i.e. no home assessment, and sometimes no equipment on discharge. We are often therefore required to make the discharge
safe, which increases the pressure on immediate intervention as well as providing equipment. We are also receiving more Acquired brain injury referrals, with significant cognitive impairment, which increases the complexity of rehabilitation, exacerbated further by the lack of neuropsychology within the team and trust. There is also no identified Neurology Consultant available to discuss medication management, treatments, or disease management.

The pathways were written into the service specification, and clearly state that the service provides a period of time specific patient centred goal mediated rehabilitation, which may have repeated spells of rehabilitation for people with long term, progressive neurological conditions. There is however a lack of provision elsewhere within Bexley, to provide a maintenance service for patients who require on-going support, to help them self-manage their condition in the community.

The Community neuro rehab team actioned 636 referrals from April 2018 – March 2019. Total referrals received over the mentioned time period including Community SLT totals 1202

Key personnel:
Every member of this team is key to its functioning. In terms of those presently dealing with the day to day management of the team you may wish to speak with:

Lead OT & previous Acting lead for team (Tues/Weds/Thurs)
Lead SLT (Weds/Thurs/Fri)
Band 7 Physio (Mon-Fri)
Lead Administrator (Mon-Fri)

Practical arrangements: address/parking/contact number etc
Bexley Adult Community Neuro Rehabilitation Team
Block A, Level 1, between Junction 4 and 5
Queen Mary’s Hospital
Frognal Avenue
Sidcup
DA14 6LT

Outstanding issues from previous visit

There are no outstanding issues from previous visits

1. In terms of what outstanding issues from last visit the team were able to recall the following:
   1) A quick win identified by Derek Tracey in terms of issues about getting patients referred to Mental Health services and the on-going difficulties the team experience with this. Email correspondence from N Black & K Chivers: No action completed
   2) Neuro psychology support – this has been addressed to some extent with N Black and Jo Cook, but this only supports Neuro Psy Ax and on a adhoc basis. On-Going
   3) On-going concerns regarding the team being split and not being able to provide an equitable service to patients within the borough of Bexley in terms of skills/knowledge mix. Also how we attract staff to a specialists area with limited specialists in each allocated LCN . Recruitment is already an issue. On -Going
   4) Recruitment – suggested Pool car use. On-Going continue to raise as an option.

Overview of visit
We met a mixture of clinical specialists and the admin team and there was a general consensus that there had been a lot of changes over the last year. The team see the majority of the patients at their home although the physio team and OT teams do run groups as well. Potential rehabilitation goals are established at triage and the team work towards achieving these.

Referrals are received from a variety of sources including GPs; hospitals; social care; self-referral; doctors; nurses etc. Some referrals from the SPA / SPC are lacking in sufficient information thereby some referrals can be sent back for more information or clarification in order to complete an efficient triage are not diagnosed and so have to be sent back. Average referrals equate to between 90-120 per month; with approx. 636 on the caseload.

Complaints can frequently be linked to patients seeking physio to do passive exercises maintenance exercises programme rather than specific goals for rehabilitation. Therapy is usually provided in a 6 week block but if clinically appropriate this is flexed up or down to meet need. We as a team experience difficulty to park at QMH Monday to Thursday, Friday being easier to park. We are a 7 day service which treats patients equally Monday to Sunday. Many of our patients need joint working but due to the individual waiting lists, PT, OT, SLT, Nur, TAP, it often means patients are seen at different times. However we always try to do joint working when it is needed.

Our current Band 8a OT gives us clear information on KPI’s and attends all Management meetings and gives us feedback efficiently at our monthly MDT meetings. KPI’s are circulated on a monthly basis to the team. We offered to get data when asked but were told it was not necessary.

The majority of visits are lone working. The team confirmed they had not accessed Skyguard as they had been told that unless they are used they devise will be taken away and the evidence base regarding use was not good. They therefore decided to not use this, however patients are risk assessed and if there is a concern then two members of staff will undertake the visit. There is also a robust lone working policy in place.

Vacancies - Band 8a Physio, band 7 PT long term sick, Band 7 SLT, band 6 OT & PT vacancy, x2 Staff members on Mat leave
Speech and Language Therapy is fully staffed at present however 1 staff are leaving. The 8b service manager role was disbanded in Nov 2018. The team felt that the changes to management structures as part of the formation of Bexley Care had resulted in a significant impact on the role of the part time 8a’s clinicians. Clinical supervision is highly valued and essential to develop and progress individuals within the team. Due to the additional work that 8As now have to do on a daily bases this limits there clinical availability for advice and guidance to the team. The team has been significantly reduced over the last 2 years with the LCN work raising anxiety and which the team feel has had a significant impact on staff vacancies.

The team felt they had been asked to give their view on the future structures and had voiced that a 3 way split was not sensible. The Senior Mgt Team (SMT) (Dir; CD and AD) had all met with the team but the outcome was not as expected, they are also concerned about the length of time this has taken and the overall impact it has had on the team eg. disbanding 8b role. They felt they had provided sufficient evidence on why the LCN model would not work in the patients favour if it were to go ahead. They also offered alternative options. Therefore they are happy with the recommended new Rehab Pathway model, which is a work in progress.
Steve asked for a view on whether bigger teams with specialisms in them could be way forward, They were positive about this and hoped that staying as a big team with CART and Reablement under one roof would work efficiently, keep all our specialities and providing a quality service to patients.

Co-location is deemed to be key factor for effective joint working, identifying estate to allow this to
happen was a challenge but the benefits of doing do was clear in equivalent teams in Greenwich.

Waiting list – patients are generally seen quickly in ESD pathways as these have 2 week goals. But the waits can be at least 18 weeks if a patient needs to be seen by all three disciplines (OT, Physio and SLT). E.g. if the SLT sees the patient then the update to RiO means they may no longer be the priority for the other 2 disciplines unless high risk is identified as other patients that have had ‘no’ intervention become the priority.

There was now a more flex approach to part time working and helps staff retention. Our current 8a OT has always been supportive and sought permission from the senior management in order to support and retain staff and given the opportunity for staff to return as part time workers according to the working policies. Staff are feeling well supported by the 8a OT, since the 8b post has been disestablished. Clinical supervisions and PDR have always been always a priority as a team and have been kept up-to-date at this difficult time, with support from the 8a OT. The 8a OT is always seeking to develop clinicians roles within the team.

There is also good leadership visibility from Lisa Cooper, either popping in or basing themselves regularly with the team.

A good day is when patients booked in are seen, and the team get to have peer support. They are positive and want to work together, open to change, and like to learn from each other. There was still a sense that senior management were not transparent and open as the explanations as to why certain views could not be supported were not always clear. Our band 8a OT has always been transparent and updated the team in a timely manner on management issues.

The teams talked about staff incentives that would help recruit and retain staff and asked about what the Trust could do to make staff feel valued e.g. revisit the voucher scheme; review AFC as one person had to take a pay cut to get train in a specialism (MSK to NEURO example).

All clinical staff were very complementary of the their strong admin team as their extensive knowledge allowed then to direct patients to the right clinician first time, they are an important part of the team allowing clinical time to be used to best effect.

Some colleagues had taken up the ½ day leave incentive linked to flu.

The concluding comment was that retaining their team specialism will mean patients categorically getting a better service and outcome.

Actions will be reviewed regularly by service directors and board visits action tracker which will be reviewed at Board every six months

<table>
<thead>
<tr>
<th>Issues raised</th>
<th>Action</th>
<th>Assigned To</th>
<th>Deadline</th>
</tr>
</thead>
<tbody>
<tr>
<td>Parking permits</td>
<td>Continue to lobby the LA for permits to allow staff to have access to easier parking</td>
<td>Sarah Burchell</td>
<td></td>
</tr>
<tr>
<td>IPads v Laptops</td>
<td>The team would like desktop functionality on the iPad as they feel there are some actions that require them to come back to base and use the desk top (Rio related).</td>
<td>Alison Furzer</td>
<td></td>
</tr>
<tr>
<td></td>
<td>They asked if there was any consideration being given to improving the iPads or providing staff with laptops. Senior management at the meeting mentioned about iPad versus Laptop. We agreed with the senior management that having the provision of Lap Tops would make our work more efficient and time saving.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>---</td>
<td>---</td>
<td></td>
<td></td>
</tr>
<tr>
<td>See outstanding actions above</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Briefing for Non-Executive Directors’ Board visits

<table>
<thead>
<tr>
<th>Date of visit</th>
<th>Service and Location</th>
<th>Attendees</th>
</tr>
</thead>
<tbody>
<tr>
<td>3rd December 2019</td>
<td>HMP Wandsworth</td>
<td>Steve Dilworth</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Keith Soper</td>
</tr>
</tbody>
</table>

**Brief description of service**

HMP Wandsworth, with an operational capacity of 1628, is one of the largest prisons in Western Europe. It is a category B local prison, with a separate category C residential unit (Trinity). Around 40% of the prisoners are un-sentenced.

The prison was built in 1851, and the residential areas remain in the original buildings. Since 1989, there has been extensive refurbishment and modernisation of the wings, including in-cell sanitation, privacy screens for cells occupied by more than one prisoner and the more recent installation of in-cell electricity.

We hold the prime provider contract for the delivery of healthcare at HMP Wandsworth. We directly provide physical health and pharmacy services and sub-contract GP (South London Prison Services), mental health and psychology (SLaM) and substance misuse services (CGL). Smaller sub-contracts are in place for other services such as podiatry, through the gate services and pathology.

There are two inpatient units at HMP Wandsworth; Addison (mental health, 12 beds) and Jones (physical health, 6 beds). We started the contract on 1st September 2019.

**Overview of visit**

This is one of a number of visits from Board members since the transfer of services to Oxleas.

We walked through the reception process in the prison, visited the first night centre, secondary screening and the inpatient mental health unit. Visitors were shown inside a cell in the inpatient unit. The room was out of commission because of damage caused to the toilet and sink. It was noted that the accommodation was very basic and sparse, but that the day room facility, located on the unit, had good natural light and access to outdoor space. The room was also used for occupational therapy activities which involved prison staff.

Because of an issue highlighted at a previous visit we went to see one of the locations from which healthcare is delivered on a wing. The issue was the security of the layout of the rooms. Staff spoken to were aware of the risk but felt comfortable with the level of officer presence and the alarm response system. The general level of equipping within rooms was observed to be good but the layout poor. It was clear that the rooms used by healthcare were largely not designed for the purposes they are currently being used.

We observed very good working relationships between prison and healthcare staff and healthcare staff continued to speak positively about their transfer to Oxleas. IT reliability and speed remains an issue, which was noted in the previous Board visit report.

We heard about the detail of the planned new healthcare facility, which was welcomed and will support the introduction of the Health and Wellbeing Model.
<table>
<thead>
<tr>
<th>Issues raised (those in grey raised on previous Board visit)</th>
<th>Action</th>
<th>By who</th>
<th>By when</th>
</tr>
</thead>
<tbody>
<tr>
<td>Permanent physiotherapy sub-contractor not in place</td>
<td>Discuss with Trust AHP Lead</td>
<td>KS</td>
<td>October 2019 - complete</td>
</tr>
<tr>
<td>Lack of inpatient beds</td>
<td>Raise with commissioners and prison</td>
<td>KS</td>
<td>January 2020 - no imminent change</td>
</tr>
<tr>
<td>Lack of wheelchair accessible cells, impacting on healthcare capacity</td>
<td>Raise with commissioners and prison</td>
<td>KS</td>
<td>January 2020 - no imminent change</td>
</tr>
<tr>
<td>Poor networks speed and reliability</td>
<td>Develop business case for the transfer of network and user support to Oxleas</td>
<td>KS</td>
<td>November 2019 – business case submitted, negotiations ongoing. NHSE have prioritised site for HSCN line installation (although this does not solve problem entirely due to poor internal infrastructure)</td>
</tr>
<tr>
<td>Health and safety of staff</td>
<td>Request Health and Safety assessment</td>
<td>KS</td>
<td>January 2020</td>
</tr>
</tbody>
</table>
Template for Non-Executive Directors’ board visits

<table>
<thead>
<tr>
<th>Date of visit</th>
<th>Service</th>
<th>Attendees</th>
</tr>
</thead>
<tbody>
<tr>
<td>2019 12 12</td>
<td>Trust wide Perinatal Service</td>
<td>Stephen Dilworth, Dr Ify Okocha, Dr Abimbola Fadipe, Sarah Hooton, Dr Sushma Sundaresh, Dr Kuljit Hunjan, Dr Alison Puffett, Caroline Oyinloye, Mercy Browne and Sarah Crowley (part of the meeting)</td>
</tr>
</tbody>
</table>

Brief description of service

The team is a Trust wide Service. They are based at Queen Mary’s hospital site in B Block, first floor temporarily and managed by the Bromley Directorate.

There was a small perinatal team in Bromley consisting of a part time consultant, part time psychologist, full time nurse and full time admin. Following a successful bid as part of the CSDF wave 2 funding, Oxleas have expanded the perinatal mental health service to provide care for women with severe or complex mental illness in Bexley, Bromley and Greenwich. The service ‘went live’ on 28/2/19 and now has a multidisciplinary team of over 20 staff.

The Current Staff

Medical staff:
- Clinical Lead and Consultant Psychiatrist for Bromley: Sushma Sundaresh
- Consultant Psychiatrist for Greenwich: Dr Alison Puffett
- Consultant Psychiatrist for Bexley: Kuljit Hunjan
- Staff grade Doctor: Darren Bull

Clinical Nurse Specialists:
- Greenwich: Caroline Oyinloye, Georgina Badejo and Veronica Olomide (0.5 wte)
- Bexley: Veronica Olomide (0.5 wte) and Noorani Bocus
- Bromley: Mercy Browne and Mariam Babatunde

HCPs:
- Alicia Sheppard Social Worker (tri-borough post)
- Catherine Hurt Occupational Therapist (tri-borough post)
- Rachel Mycroft Lead Clinical Psychologist
- Joni Paton Clinical Psychologist (Bromley)
- Sara Roberts Counselling Psychologist (Greenwich)
- Sarah Crowley Clinical Psychologist (Bexley)
- Kirsty Carmichael Clinical Psychologist (Bexley and Bromley)

Nursery Nurses:
- Zoe Wood (Greenwich / Bexley)
- Rachel Andrews (Bromley / Bexley)

Admin / care navigators:
- Leanne Rickard
- Sharon Burman

Team Manager
Sarah Hooton (covering maternity leave for Jolaade Ajiferuke)

The service is for women resident or with a GP in the boroughs of Bromley, Bexley and Greenwich. They see women with diagnosis of bipolar affective disorder, Schizophrenia / Schizoaffective disorder, previous postpartum psychosis, other psychotic illness and those women with a family history of postpartum psychosis. These women should be referred even if they are currently well. The team also work with women with PTSD, eating disorders, OCD and personality disorders. Women who are already under the care of a CMHT or have a psychiatric inpatient admission during pregnancy or in the post natal period should also be referred. They offer pre-conception advice for women with SMI and medication advice.

About 20% of women in pregnancy experience mental health distress. The team see the 5% of women that have severe mental health problems in pregnancy.

The team see women in antenatal departments, Children’s centres, health centres and in women’s homes. Currently women remain in the service until the baby’s first birthday.

There are proposals in the 10 year long term to expand the remit of Perinatal services from April 2020. This will include working with fathers and being more family focussed. They will also be expected to work with the family until the child’s second birthday.

They work with colleagues both internally and externally:
- 3 maternity sites (QEH, PRUH and Darent Valley Hospital)
- 3 health visiting teams
- 3 IAPT teams (2 externally provided)
- 3 local authorities
- 2 mental health liaison services
- 3 Home Treatment teams
- 9 community mental health teams (EIP, ADAPT ICMP)

They also work with women with lived experience and Third sector organisations such as MIND, Mumsaid, Cocoon Family support, Maternal Journal. The model of the service was coproduced with Cocoon.

Overview of visit

Discussion with the team:

- Objective to see 600 patients in first year and currently expected to exceed this as there have been 530 referrals in first 3 months and 320 have been seen. Those not accepted are signposted to an appropriate service.

- They have a 30% DNA rate. This is for first appointments they are drilling down as to reasons why. Seems high but drops down to 10% once engaged. Staff felt that video connection may not help with this cohort.

- 4 weeks waiting list for non-urgent referrals. They felt this was OK and in line with National guidelines.

- 2 former staff from SLaM. All spoke highly of team culture and Oxleas as an organisation, although critical points below also noted.

- There is very good Multiagency working. There was a Midwife from the PRUH attending the MDT on the day of our visit. They also provide supervision for Midwives across the Maternity sites.

Actions will be entered on to Board visits action tracker which will be reviewed at Board every six months

<table>
<thead>
<tr>
<th>Issues raised</th>
<th>Action</th>
</tr>
</thead>
<tbody>
<tr>
<td>Skyguard requested but this was declined. This caused us some shock and needs urgent attention. Our understanding is that all staff who request this will get it.</td>
<td>Dr Okocha has written to the Bromley DMT and asked that this be reviewed. The team manager has been asked to put the request in. The Bromley DMT will monitor the use of the equipment.</td>
</tr>
<tr>
<td>Difficulty in obtaining space in some</td>
<td></td>
</tr>
<tr>
<td>Children Centres in Greenwich and Bexley. It would be good to have space in areas that are well served by public transport. Such as Eltham and QMH site. The team are currently being charged for use of clinical space on the QMH site.</td>
<td></td>
</tr>
<tr>
<td>---</td>
<td></td>
</tr>
<tr>
<td>• Complaint on response time from Greenwich AMHP Service to arrange MHA assessments. Needs to be within 4 hours but “days” being quoted- not acceptable.</td>
<td></td>
</tr>
<tr>
<td>• Problem on theft from car and bicycle wheels in QMH car park. Is there more support we should be giving on this? Seems tough that we are not protecting staff possessions and/or providing staff better support for crime in staff allocated areas.</td>
<td></td>
</tr>
<tr>
<td>Sarah Hooton, team manager, is still liaising with the Children Centres to resolve this</td>
<td></td>
</tr>
<tr>
<td>Dr Okocha has written to Helen Jones, Greenwich Service director requesting response to this complaint.</td>
<td></td>
</tr>
<tr>
<td>The matter has been referred to Rachel Evans.</td>
<td></td>
</tr>
</tbody>
</table>
Report Title | Council of Governors Update
---|---
Author | Sally Bryden, Associate Director of Corporate Affairs/Trust Secretary
Accountable Director | Andy Trotter, Chair
Confidentiality/FOI status | Public

Report Summary

Trust Strategy Development – Our Next Steps
To ensure governor views are part of our strategy development programme, a specific engagement event for governors was held on 12 December 2019.

Governors also participated in the Closer to Home events to which members had been invited.

Council of Governors’ meeting – 12 December 2019
At the Council of Governors’ meeting, the following items were discussed:
- Plans to improve services and support for people experiencing a mental health crisis
- Charitable funds
- NED Nominations Committee report including re-appointment of Yemisi Gibbons as a Non-Executive Director
- Steve James, Non-Executive Director, presented a report on his activities
- NED remuneration committee report
- Membership Committee report
- Quality Improvement annual update
- Indicators for Quality Report
- South London Partnership provider collaborative submission
- South East London community services NHS Long term plan submission

Governor visits
The following visits are confirmed for January and February 2020:

29.01.20 Oxleas House, Queen Elizabeth Hospital – to receive an update from the Greenwich Adult Service Director, find out about Oxleas House and the Crisis Pathway and visit inpatient services.

30.01.20 HMP Wandsworth – to receive an update from the Forensic and Prison Service Director and visit health services at the prison.

31.01.20 Pinewood House - update on carers and patient experience from Head of Patient Experience and Patient Safety
11.02.20 Carlton Parade – to receive an update from the Bromley Service Director and visit Bromley East locality services.

<table>
<thead>
<tr>
<th>Purpose (To select purpose, click on relevant choice for drop down box)</th>
<th>Information</th>
<th>To Note</th>
<th>Approval</th>
<th>Decision</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Recommendation</th>
<th>Board members are asked to note the update.</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Link to strategic objectives (click on relevant choice for drop down box)</th>
<th>Quality</th>
<th>Workforce</th>
<th>Sustainability</th>
<th>Partnerships</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Link to Board Assurance Framework</th>
<th>There are no direct links to the BAF</th>
</tr>
</thead>
</table>