NHS
South London and Maudsley
NHS Foundation Trust

REPORT TO THE HEALTH & SOCIAL CARE SUB COMMITTEE

25 September 2018

Title	CQC inspection July – August 2018 outcomes and response to regulation 29A warning notice.
Author	Mary O'Donovan, Head of Quality
Responsible Director	Beverley Murphy, Director of Nursing

Purpose of the report

1. To report the initial findings and outcome of the Core Service and Well Led inspections by the CQC in July – August 2018.

2. To note the key issues raised and the highlighted risks.

3. To share the updated corresponding BAF risk.

4. To outline the improvement work underway.

5. To outline the proposed governance of the improvement plan and the need to include the Quality Committee Chair and NED members in the approval of the improvement plans.

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

Summary

This report outlines the following:

- Process of CQC Inspections 2018
- Early feedback (verbal) from the CQC
- Regulation 29A (HSCA) warning notice regarding the Acute and PICU pathway
- Immediate actions taken following warning notice
- Focus of improvement actions underway
- Proposed governance structure developed to monitor improvement plan implementation

CQC Inspection July–August 2018
Outcomes and Response to Regulation 29A Warning Notice

1.0 Introduction

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

	Safe	Effective	Caring	Responsive	Well-led	Overall
TRUSTWIDE	Requires Improvement	Good	Good	Good	Good	Good
Acute wards for adults of working age and psychiatric intensive care units- Inspected 2017	Requires Improvement	Requires Improvement	Good	Good	Requires Improvement	Requires Improvement
Community-based mental health services for older people- Inspected 2015	Requires Improvement	Good	Good	Good	Good	Good
Forensic inpatient/secure wards- Inspected 2015	Requires Improvement	Good	Good	Requires Improvement	Good	Requires Improvement
Mental health crisis services and health-based places of safety- Inspected 2015	Requires Improvement	Good	Good	Good	Good	Good
Specialist Services- Eating Disorders and Lishman- yet to be rated	Awaiting rating	Awaiting rating	Awaiting rating	Awaiting rating	Awaiting rating	Awaiting rating
Rating Key	Inadequate	Requires Improvement	Good	Outstanding		

Table one: CQC Trust Ratings: June 2018

2.0 CQC Inspection Process

The table below outlines the CQC inspection timeframe/process.

Date - Month/Week	Inspection process
20 March 2018	Notification of CQC inspection received by the Trust
12 April 2018	Provider Information return (data submission)
2- 4 July 2018	Inspection- Forensic Inpatient, Community MHOA, Crisis Services and Specialist Services
9-11 July 2018	Inspection- Acute pathway
16 July 2018	High level CQC verbal Feedback
25 July 2018	CQC Warning Notice (draft)- Acute and PICU Pathway
31 July 2018	Governors Focus group
08 August 2018	SLaM representation: Warning letter
13 August 2018	CQC representation outcome- revised warning notice
14- 20 August	Well Led inspection Focus Groups

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

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

PIR	Number of data requests
Mental Health specific	• 12 data requests • 2 document requests
Universal	• 77 data requests • 45 document requests

Table three: PIR data requests March/April 2018

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

Service Area	Number of Actions taken
Pharmacy/medicines	2
Corporate	4
Specialist	2
Crisis	4
Acute/PICU	28
Forensic	1
MHOA community	2
Total	43

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

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

3.0 Verbal High Level Feedback

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

Feedback	Challenges
FORENSIC INPATIENT - **Improved since last inspected.** - **Significant reduction in violence and good use of restraint reduction measures.** - **Good physical health care and care planning.** - **Good easy read information.** - **Strong team work.** - **Staff have freedom to innovate.** - **Good psychology provision and restorative justice noted as positive.** - **Good use of zoning.** - **Can see work and efforts on food and good that self-catering is being considered however, the service users offered mixed feedback on the food itself.**	Staff on Norbury failed to escalate the drug fridge temperature despite noting it was too high. Not enough detail about individual episodes of restraint being captured. Sharing of learning lessons from all kinds of incidents varied between wards. Effra ward had infrequent team meetings. Norbury ward was noted as being a stressful ward to work on. Questions about the frequency of s132 rights being repeated – CQC considering further. Issues with short staffing. Lack of clear action following audits.
EATING DISORDERS o **Improved in all of the challenged areas identified in the February 2018 inspection.** o **Good use of clinical research to inform practice.** o **Good that staff are trained to work with people with autism.** o **The staff are all caring.** o **FREED has many positive aspects.**	Documentation of restraint – although noted restraint is rarely used. Lack of training and competency checks for new staff. Insufficient social work and dietetic provision. The lack of the ward manager post is thought to have an adverse impact.
MHOA COMMUNITY o **Ability to access GP records for physical health care (L, S, L) is good.** o **Strong MDT working (Lam & Lew).** o **Improved waiting times.** o **Good knowledge base and evidence base informing practice.** o **Positive service culture.** o **Evidence of research informing practice.** o **Positive impact of good senior leadership team.**	Patients own medication being used / reused in HTT and a lack of a system to track use and returns of medication. Insufficient mobile technology to enable clinicians to work effectively (L, S, L). Could obtain more feedback on the service from people with dementia.

o **Decrease in the use of anti-psychotic medication in people with dementia.** o **Good use of technology - Apps** o **Detailed clinical assessments.** o **Very caring staff.** o **Working in schools to beat stigma and also the work to improve BME access.**	Care plans could be more dementia friendly. Learning lessons from all kinds of incidents was inconsistent as were team meetings. Accessing physical health care information from Croydon GPs.
CRISIS SERVICES o **Good risk management.** o **Good use of zoning.** o **Good use of psychology.** o **Decrease in length of stay – HBPoS.** o **Good safeguarding and physical health care.** o **Personalised care planning.** o **HBPoS – really good multi agency interface including working with police and AMHPs.** o **Good that parents are able to stay with children.** o **HBPoS – good environment.** o **CAT – good initiative to divert people where service not required.** o **Experienced managers and move to Boroughs is helpful.**	Use of patients own medication and system for this. CRHT splitting doses from pharmacy – needs review. High use of bank (CRHT). High caseload in Lambeth. Insufficient supervision. Capacity assessments not detailed enough or always there. Patients' rights poster in HBPoS incorrect.
ACUTE and PICUS o **Safeguarding was strong across the board.** o **Impact of 4 steps to safety was seen as positive.** o **Use of E-Obs seen as positive.** o **Use of red to green days (JBU).** o **Clare ward had addressed significant concerns following previous inspections.** o **Positive use of NRT.** o **Consistent approach to fire safety and fire safety audits.** o **Supervision noted to be improving.** o **ES2, JBU and Powell were noted to be 'excellent' wards.**	Recording or physical health care following rapid tranquilisation (RT) was a problem across all wards. ES1 garden – fire escape from ES2. Access to drinking water on Johnson ward. Consistent control of environmental hazards (during the week 6 Ligature Anchor Points were identified not on assessment, there was 4 blind spots identified) and a lack of risk assessment in relation to the use of plastic bin liners. Lack of progress with reducing prone restraint and the use of RT. Learning from incidents of all kinds was not in place, not facilitated by team meetings.

	Access to beds and flow for patients is a significant issue. A lack of discharge planning leading to timely and well-prepared discharges (although JBU and LK noted to stand out for positive practice). The trust was noted to be less proactive than other trusts with similar demands. Croydon noted to have specific difficulties. Patients in the ARC awaiting the availability of a bed. The attitude of AL2 staff was concerning and there was poor feedback from the patients about their care – expert by experience had concerns about quality. Croydon PICU patients were not positive about the care they received. Unwarranted variation across wards with increased concern about FM1, AL2, JD ward, Nelson ward, Virginia Wolf ward, TW1 & Croydon PICU.
Well led week o **High calibre Board.** o **Chair and CEO 'exceptional' leaders.** o **Exceptional partnership working – SLP and Alliances.** o **Evidence of research being used in practice.** o **Greatly improved relationship with Governors.** o **Innovative use /development of technology.** o **Some very good physical health practice, specifically the support offered to people to lead healthier lifestyles.** o **Serious incident investigations go beyond requirements and are thoughtful.** o **Care plans have improved.**	Unwarranted variability in the quality of care. Strategy is not fully formed; some staff are 'vague' about what it is / means. Lack of clear offer to develop staff leadership abilities. WRES action plan although initiatives and actions welcomed time and consistent effort is needed for it to have impact. QI – a good start is evident however it needs to be spread across all parts of trust and needs embedding. LGBT and lived experience networks need to grow. Accessible Information standard needs to have impact in practice. Patchy knowledge of Freedom to speak up guardian role. The advocates would benefit from development and staff raised

	questions about the opportunities being advertised. Staff side raised questions about having enough supported time to deliver against demands. Supervision is patchy and inconsistent across the Trust. Team meetings and the accountability for making them happen need to improve. The improvement plan for EPPR needs to be delivered and embedded. The Trust has a comparatively low number of peer support workers and the CQC hope to see us employ more.

Table five: CQC Verbal feedback

4.0 CQC Improvement Notice- Acute and PICU Pathway

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

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

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

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

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

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

The corresponding BAF (BAF 7) has been reviewed and is attached at appendix 1 for consideration and approval.

4.1 Governance of our Improvement Plan

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

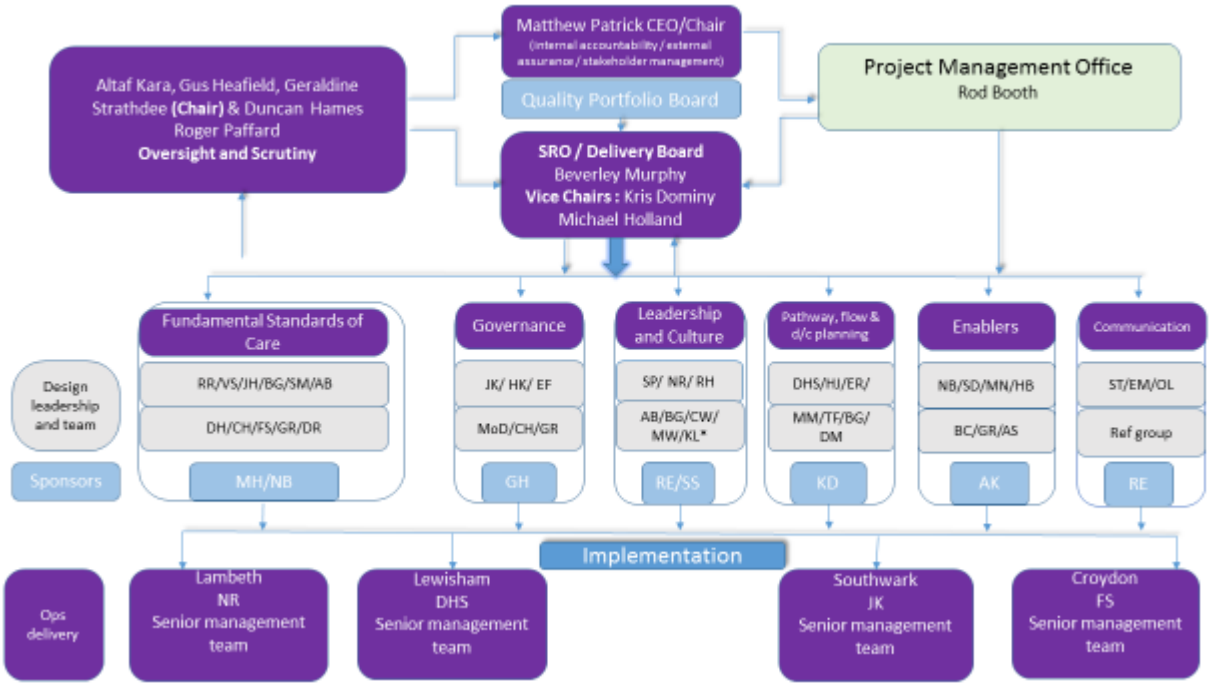
These discussions resulted in the following priority areas for improvement:

(i) Fundamental standards of care
(ii) Governance
(iii) Leadership and culture
(iv) Clinical pathways including flow and discharge planning.

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

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

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



Governance Chart- Improvement Plan implementation

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

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

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

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

The principle purpose of the Our Improvement Plan Quality Portfolio Board is:

Strategic Oversight: Implementation and Delivery of Our Improvement Plan

a) Ensuring alignment of Our Improvement Plan with the vision, values and culture of clinical governance, quality, patient safety and clinical standards across the organisation
b) Promoting clinical leadership and engagement in the development and delivery of Our Improvement Plan
c) Reviewing and ensure that lessons from delivery of Our Improvement Plan are learned and implemented across the organisation
d) Receiving reports from the Trust Management Board and, where relevant, ensure implementation of recommendations via Our Improvement Plan work streams. These recommendations could result from:

    - Quality Committee recommendations
    - Internal reports
    - External reports
    - Clinical audit reports
    - Clinical accreditation visits
    - Service reviews
    - Legislation, regulations and guidance which address clinical governance, quality, patient safety and clinical standards

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

Risk management and internal control

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

Finance

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

The draft terms of reference are at Appendix 3.

The principle purpose of Oversight and Scrutiny is:

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

The draft terms of reference are at Appendix 4.

4.2 Improvement Underway

The initial feedback given by the CQC was recognised by the trust leadership, we had already identified a problem. The reorganisation of the delivery arm of the Trust into Operational Directorates was specifically designed to address many of the issues raised. Service Directors, working with Clinical

Directors and Operational Directorates now have an area of responsibility that significantly improves local leadership and oversight. The inspection occurred within weeks of the transition being made hence why the actions of the leadership had not yet made an impact with creating consistency in the quality of care.

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

4.3 Immediate Actions Taken

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

4.3.1 Targeted Action at Borough Level

The new borough leaders have been engaging directly with teams in the acute pathway to drive immediate improvements to standards in the areas identified in the notice. These will report regularly to the Delivery Board.

4.3.2 Post Rapid Tranquilisation Physical Health Care Monitoring

Have developed a co-produced training module for roll out across all inpatient units. The training sets out clear requirements in relation to post-rapid tranquilisation, together with Quality Improvement methodology to support each team to understand how to achieve consistent standards.

4.3.3 E-observations

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

4.3.4 Risks to Quality – using data effectively

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

4.3.5 Care pathway, flow and discharge

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

4.3.6 Engaging our Staff on the Improvements

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

4.3.7 ES1 garden – risk of fall from height

The environmental improvements to remove this risk are now complete.

4.3.8 Staff Networks

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

4.3.9 Trust Strategy – Changing lives

The Board will receive the final version of the strategy on 18th September 2018 following which there will be a number of planned launch events across the Trust during October and beyond. This will include a number of 'I' statements about what our strategy will mean for our service users.

5.00 Approving our Improvement Plan

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

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

6.0 Conclusion

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

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

It is the aim of the Trust to evidence and demonstrate what we have delivered significant further change within the period of the warning notice, focusing on improving outcomes for patients and staff. Some of the improvements will be able to be delivered quickly and we are pressing ahead with these at pace. However, we also recognise that for change to be sustained, some improvements will take longer to

achieve and longer still to embed. This work will extend beyond the life of the warning notice. We want our improvement plans to be delivered in three six-month phases so that we can prioritise the actions that will have the greatest impact, monitor outcomes and deliver maximum engagement.

Mary O' Donovan
Head of Quality
29 August 2018

Appendix 1: BAF risk 7

Appendix 2: Draft terms of reference Delivery Board

Appendix 3: Draft terms of reference Quality Portfolio Board

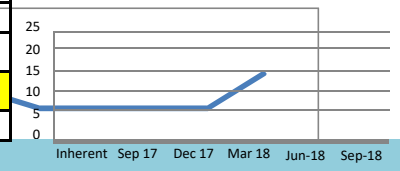
Appendix 4: Draft terms of reference Overview and Scrutiny Group

APPENDIX ONE – BAF RISK 7

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

			Initial	Current	Target
Owner:	BM / DoN	**Likelihood**	3	4	2
Committee:	Quality committee	**Consequence**	4	4	3
Proximity:	12 months	**Level**	12	16	6
Risk Category:	Quality (patient safety, experience & clinical outcomes)				
Risk Appetite	Cautious (nominal range 3-8)	**Last reviewed**	Jun-18	**Next review**	Sep-18

Trend



Potential Causes *(links to the CRR)*

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

Potential Consequences

Services and staff become overly focussed in maintaining status quo and do not have the capacity to improve and transform. In the current context this could lead to an adverse impact on quality of care which ultimately could lead to the trust failing to meet the required improvement actions (Must do / Should do) as set out in inspection reports. This could lead to regulatory action and loss of services.

Key Controls

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

Gaps in Control

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

Sources of Assurance

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

Gaps in Assurance

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

Appendix Two

RIGHT CARE
Delivery Board
Terms of Reference (ToR)
V4 0

Document history:

Author(s)	Changes	Circulation	Date
PMO	Initial draft	Rod Booth, Beverly Murphy	21/08/18
Beverley Murphy	Redrafting	SMT	22/08/18
Beverley Murphy	Redrafting	SMT members	24/08/18

1. Authority and function

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

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

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

2. Project Board Objectives

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

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

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

3. Membership

The membership and responsibilities are as set out below:

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

Additional support will be requested as required

4. Quorum

To be quorate, the chair, or one vice chair must be present with at least two other members.

5. Frequency of meetings

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

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

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

6. Meeting Governance

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

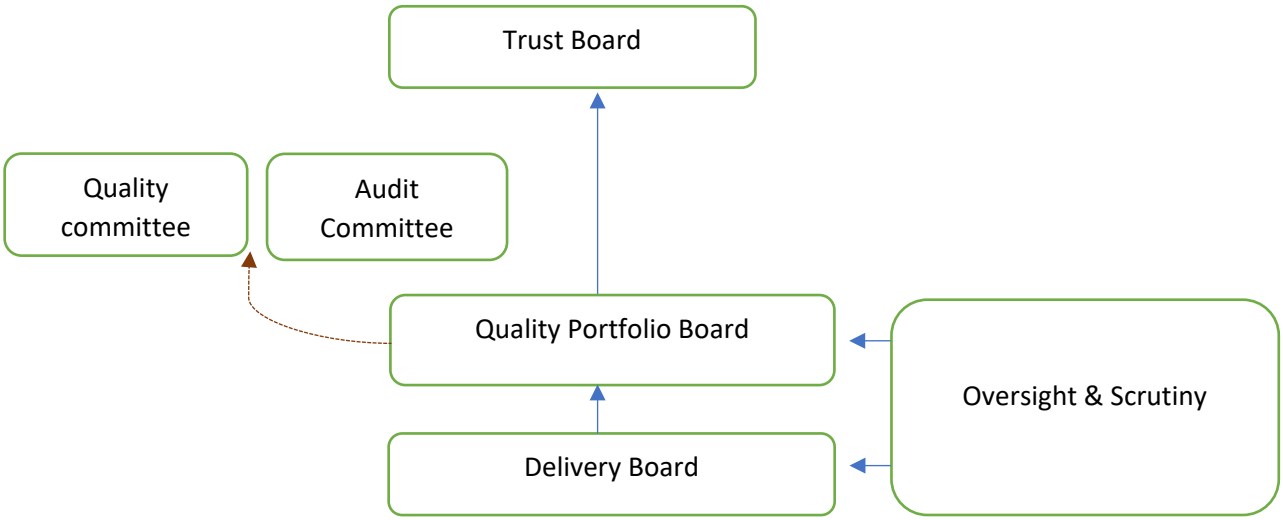
The quorate team will escalate issues where appropriate based on changes to quality, cost and time that are outside of approved limits of either SFIs, SOs, or those set at the Trust Board.

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

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

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

Organisational structure



7. Review

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

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

Appendix three

'Our Improvement Plan' Quality Portfolio Board (OIPQPB)

Terms of Reference (ToR)
V2

Document history:

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

1. Authority

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

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

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

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

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

The Improvement Plan Quality Portfolio Board is accountable to the Board of Directors and any changes to these terms of reference must be approved by the Board of Directors.

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

Overview and Scrutiny Group Dependencies

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

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

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

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

2. Quality Portfolio Board Objectives

Strategic Oversight:
Implementation and Delivery of Our Improvement Plan

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

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

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

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

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

- Quality Committee recommendations
- internal reports,
- external reports,
- clinical audit reports

- clinical accreditation visits
- service reviews
- legislation, regulations and guidance which address clinical governance, quality, patient safety and clinical standards

Risk management and internal control

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

Finance

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

3. Membership

The Quality Portfolio Board will include the following members:

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

All members listed above have voting rights.

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

Name	Role	Responsibilities
Matthew Patrick	Chair	To lead the Board and provide strategic direction
Beverley Murphy	Deputy Chair	Support leadership of the Board & the strategic direction
Kris Dominy	Member	Support leadership of the Board & the strategic direction
Michael Holland	Member	Support leadership of the Board & the strategic direction
Gus Heafield	Member	Support leadership of the Board & the strategic direction

Altaf Kara	Member	Support leadership of the Board & the strategic direction
Rod Booth	Member	PMO, Governance and Operational Assurance

4. Quorum

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

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

5. Frequency of meetings

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

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

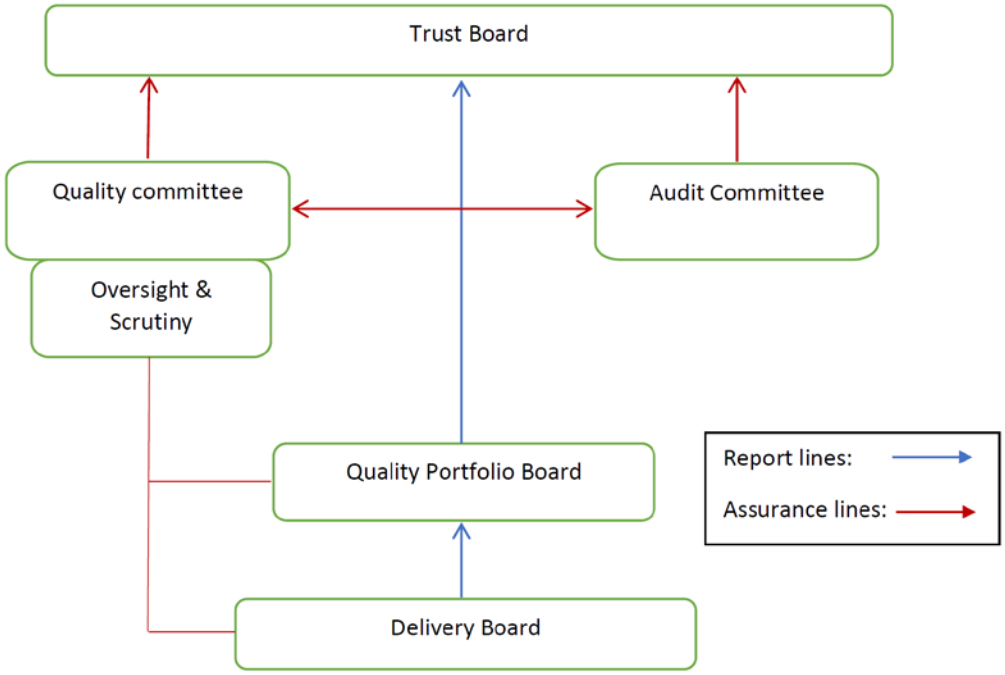
The business of each meeting will be transacted within a maximum of two and a half hours.

6. Meeting governance

Members of the board have a responsibility to:

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

6. Programme Organisational Structure



8. Review

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

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

Appendix four

Draft Terms of Reference (ToR)

Overview and Scrutiny Group for Our Improvement Plan

Document history:

Author(s)	Changes	Circulation	Date
Altaf Kara	Initial draft	OCSIP	30/08/18
Geraldine Strathdee	Comments to initial draft	OSCIP	30/08/18
Roger Paffard	Comments to initial draft	OSCIP, Quality Committee Chair, BDIC Chair	31/08/18
Matthew Patrick	Comments to initial draft	OSCIP and Quality Committee Chair	04/09/18
Altaf Kara	Final draft	OSGIP and Quality Committee Chair	05/09/18

1. Authority and Function

The Overview and Scrutiny Group of Our Improvement Plan's (OSGIP's) primary function is to provide challenge and oversight to the improvement plan arising from the CQC inspection acting equally as a *critical friend* to the executive team and as an *assurance mechanism to the Board*. OSGIP is not a decision making body

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

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

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

In its role as an *assurance mechanism to the Board,* OSGIP will act as a defined

sub-group of the Quality Committee that is dedicated to this task, invited by the Chair of the Quality Committee to present views at the Board on a monthly basis and empowered to engage all committee chairs, including of the Quality Committee and Audit Committee, in contributing to the work on how our governance should evolve.

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

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

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

2. OSGIP Objectives

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

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

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

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

3. Membership

The membership and responsibilities are as set out below;

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

Additional support will be requested as required

4. Quorum

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

5. Frequency of Meetings

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

Papers will be submitted one week in advance to the PMO [subject to dates], who will provide secretariat support to OSCIP.

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

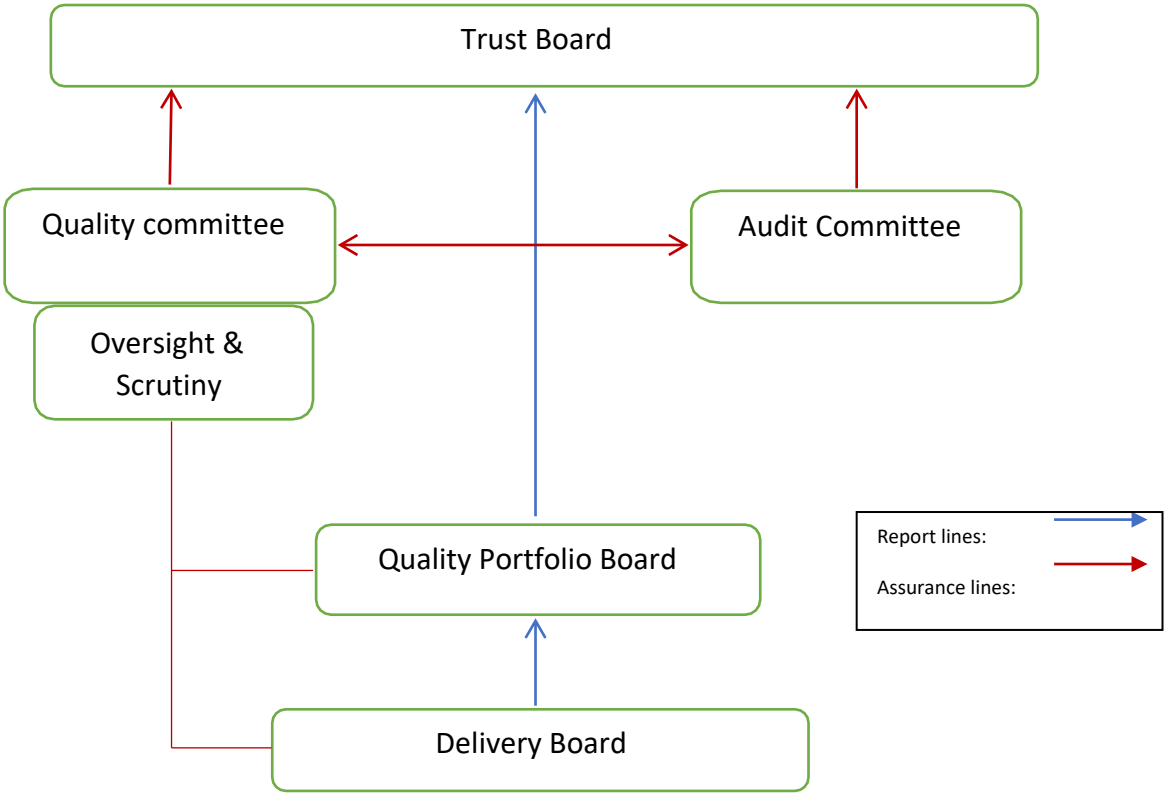
6. Meeting Governance

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

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

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

7. Organisation Structure



8. Review

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

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

Health & Social Care Sub Committee 25th September 2018







CQC ratings 2017

	Safe	Effective	Caring	Responsive	Well-led	Overall
Acute wards for adults of working age and psychiatric intensive care units	Requires Improvement	Requires Improvement	Good	Good	Requires Improvement	Requires Improvement
Community-based mental health services for adults of working age	Requires Improvement	Requires Improvement	Good	Requires Improvement	Good	Requires Improvement
Mental health crisis services and health-based place of safety	Requires Improvement	Good	Good	Good	Good	Good
Wards for children and young people	Good	Good	Good	Good	Good	Good
Community-based mental health services for children and young people	Good	Good	Good	Good	Good	Good
Forensic inpatient/secure wards	Requires Improvement	Good	Good	requires Improvement	Good	requires Improvement
Wards for long-stay/rehabilitation - working age adults	Requires Improvement	Good	Good	Good	Good	Good
Wards for older adults	Requires Improvement	Good	Good	Good	Good	Good
Community-based mental health services for older adults	Requires Improvement	Good	Good	Good	Good	Good
Community-based mental health services - learning disabilities or autism	Good	Outstanding	Outstanding	Good	Outstanding	Outstanding
Wards for people with learning disabilities or autism	Good	Outstanding	Outstanding	Good	Outstanding	Outstanding
Trustwide	Requires Improvement	Good	Good	Good	Good	**Good**

Scope and Purpose

Purpose

- CQC Compliance, Well Led Inspection

Scope

- July 2018 (2 weeks) - Compliance Inspection
- 5 Pathways Inspected
  - Acute
  - Specialist services- Eating Disorders and Lishman Unit
  - Crisis Services
  - Forensic Inpatient
  - Community based mental health services for Older people
- August 2018 (1 week)- Well Led Inspection

Overall verbal feedback

- Recognised improvement in pathways
  - Specialist services- Eating Disorders and Lishman Unit
  - Crisis Services
  - Forensic Inpatient
  - Community based mental health services for Older people
- Risk assessments and care plans Improved

BUT

- Improvement is needed in the acute wards

Regulation 29A warning notice

Two key areas of concern

- Unwarranted variation
  - time, place and issue

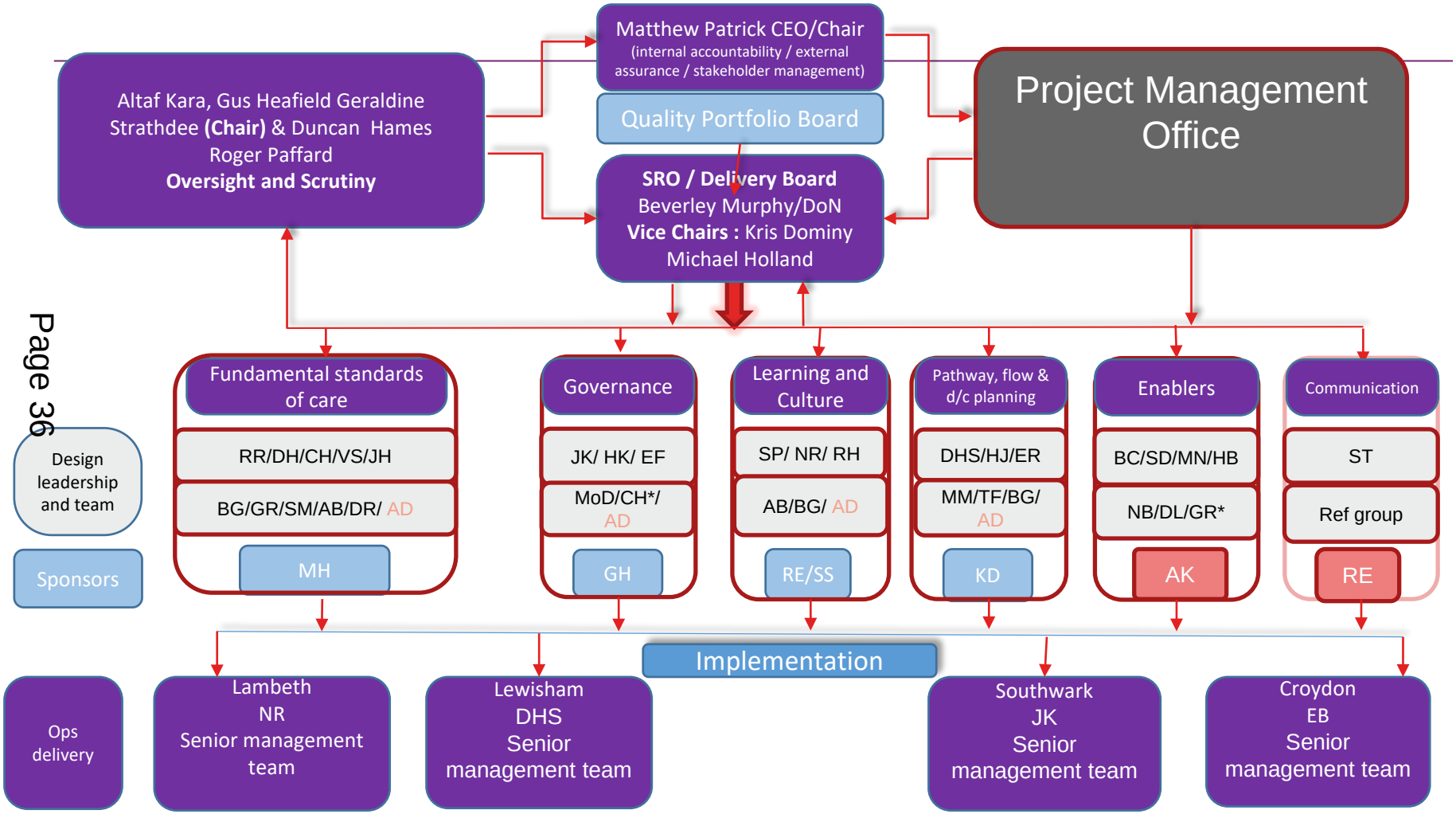
- Unknown unknows - not sighted on quality issues

Diagnosis

- Structure and Governance
  - CAG structure and span of control
  - Directorate to floor governance
- Culture and leadership
  - Individual excellence and assumed autonomy
  - Accountability and action against fundamental standards of care
  - QI vs IQ
- Demand and Flow
  - Bed pressures – fatigue and habituation
  - Partner agency cuts and system pressures (e.g. LAs,ED)
  - Chronic underfunding of services

Agreed focus of improvement

1. Fundamental standards of care
2. Leadership and culture
3. Governance
4. Pathway flow and discharge planning
5. Key enablers – IT, estates and BI .
6. Communication


Matthew Patrick CEO/Chair
(internal accountability / external assurance / stakeholder management)
Quality Portfolio Board
Altaf Kara, Gus Heafield Geraldine Strathdee (Chair) & Duncan Hames
Roger Paffard
Oversight and Scrutiny
SRO / Delivery Board
Beverley Murphy/DoN
Vice Chairs : Kris Dominy
Michael Holland
Project Management Office
Design leadership and team
Sponsors
Fundamental standards of care
RR/DH/CH/VS/JH
BG/GR/SM/AB/DR/ AD
MH
Governance
JK/ HK/ EF
MoD/CH*/ AD
GH
Learning and Culture
SP/ NR/ RH
AB/BG/ AD
RE/SS
Pathway, flow & d/c planning
DHS/HJ/ER
MM/TF/BG/ AD
KD
Enablers
BC/SD/MN/HB
NB/DL/GR*
AK
Communication
ST
Ref group
RE
Implementation
Ops delivery
Lambeth
NR
Senior management team
Lewisham
DHS
Senior management team
Southwark
JK
Senior management team
Croydon
EB
Senior management team