A MEETING OF THE BOARD OF DIRECTORS OF THE SOUTH LONDON AND MAUDSLEY NHS FOUNDATION TRUST
WILL BE HELD ON TUESDAY 25TH JUNE 2013 AT 3:00pm BOARDROOM, MAUDSLEY HOSPITAL

AGENDA

1 APOLOGIES for absence:

2 Declarations of Interest

3 Minutes of the Board Meeting held on 28th May 2013

   Attached Minutes from the Service Quality Improvement Committee May Meeting

4 MATTERS ARISING

RATIFICATION

5 To ratify a recent Consultant Appointment

Page 13 App A

PRESENTATION

6 To receive a Presentation on Kings Health Partners

Page 14 App B

7 To receive a Presentation on the R&D Annual Report & Operational Capability Statement

Page 15 App C

QUALITY

8 To receive the Service Quality Indicator Report & the Exception Report on Infection Control Surveillance

Page 36 App D

9 To receive the SLaM Clinical Audit Annual Report 2012/13

Page 44 App E

PERFORMANCE AND ACTIVITY

10 To discuss the Finance Report Month 2

Page 59 App F

GOVERNANCE

11 To receive a Report from the Acting Chief Executive

Page 69 App G

12 To receive an Update from the Council of Governors

Page 72 App H

13 To receive the Changes to the FT Constitution

Page 75 App I

14 To receive the Safeguarding Children Arrangements Declaration of Compliance

Page 78 App J

INFORMATION

15 Director’s Reports

Verbal

16 Forward Planners

Page 88 App K

17 Any other business

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

Date of Next Meeting: Tuesday 23rd July – 3:00pm, Board Room, Maudsley Hospital, Denmark Hill, London, SE5 8AZ. Please send apologies to Alison Baker 0203 228 4763

alison.baker@slam.nhs.uk

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

web site: www.slam.nhs.uk
MINUTES OF THE SIXTY FIFTH MEETING OF THE BOARD OF DIRECTORS OF THE
SOUTH LONDON AND MAUDSLEY NHS FOUNDATION TRUST
HELD ON 28TH MAY 2013

PRESENT
Madeliene Long Chair
Dr Martin Baggaley Medical Director
Dr Patricia Connell-Julien Non Executive Director
Harriet Hall Non Executive Director
Gus Heafield Acting Chief Executive
Kumar Jacob Non Executive Director
Prof Shitij Kapur Non Executive Director
Zoë Reed Director of Strategy & Business Development
Dr Jane Sayer Acting Director of Nursing and Education

IN ATTENDANCE
Mark Allen Service Director, Addictions CAG
Alison Baker PA to Chair & Non Executive Directors
Lucy Canning Service Director, Psychosis CAG
Eleanor Davies Service Director, B&DP CAG
Tim Greenwood Deputy Director of Finance
Kay Harwood Head of Planning and Equality and Diversity
Roy Jaggon Head of Performance
Paul Mitchell Trust Board Secretary
David Norman Service Director, MHOA CAG
Mark Nelson Assistant Director of Finance
Louise Norris Director of Human Resources
Noel Unwin Vice Chair, Members’ Council

APOLOGIES
Sam Antwi-Marful Deputy Director, B&DP CAG
Robert Coomber Non Executive Director
Dr Tom Craig Director of Research and Development
Steve Davidson Service Director, Psych Medicine and MAP CAGs
Nick Dawe Director of Finance

DECLARATIONS OF INTEREST
Routine declarations were made:

- Madeliene Long declared an interest as a Lewisham Borough Councillor and an Honorary Fellow of King's College London.
- Zoe Reed declared an interest as Chair, of Society for Anglo Chinese Understanding.
- Dr Patricia Connell-Julien declared an interest as a former employee of Kings College London and as a Trustee of Southside Certitude Support.
- Prof Shitij Kapur declared an interest as a member of the CNS Scientific Advisory Board of Lundbeck Co and Roche Co. Prof Kapur advises and consults with pharmaceutical companies periodically.
MINUTES

The minutes of the meeting held on the 30th April 2013 were agreed as an accurate record of the meeting.

Madeliene Long commented that this was Louise Norris’ last Board of Directors meeting as she would be leaving SLaM on 30th June to take up the role of Director of Human Resources at Central and North West London NHS Foundation Trust. Louise had made a significant contribution to the Trust in the nine years that she has worked here, providing strategic leadership and direction in an area that is of critical importance to the organisation. On behalf of the Board of Directors, Madeliene Long wished her well in her new role.

BOD 56/13 MATTERS ARISING

There were no matters arising from the previous minutes.

BOD 57/13 RATIFICATION

The Board of Directors ratified the recent Consultant post:

Dr Karine Macritchie – Consultant Psychiatrist, Affective Disorders Unit (ADU)

The Board of Directors ratified the recent Consultant post.

BOD 58/13 PRESENTATION – KING’S HEALTH PARTNERS (verbal)

Madeliene Long explained that it had been agreed that Professor Sir Robert Lechler would now attend the Board of Directors June meeting to give a presentation.

Madeliene Long reported that a recent meeting with CAG leaders had been positive in addressing opportunities to shape the future. Dr Martin Baggaley emphasised that senior clinical staff wished to be bold with their thinking.

Madeliene Long reported that work was ongoing with McKinseys in the development of the full business case. A meeting of the KHP Partnership Board was taking place the following day to discuss the PRU acquisition.

The Board of Directors noted the verbal report.

BOD 59/13 SERVICE QUALITY INDICATOR REPORT & INFECTION CONTROL

Gus Heafield explained to the Board of Directors that this report now contained the Infection Control report, where there were no issues to report within the month.

Roy Jaggon explained that this was month 1 report for the new financial year. Work continued with Grant Thornton to ensure consistency with guidance for performance indicators to ensure that differences in interpretation were the result of adhering to best clinical practice and that the Trust had comprehensive and robust documentation.

Access to CRB data and use in this the report was still under development, which would need to be in place by the end of quarter 1. Violent incidents showed an increase over the same period as last year, this was primarily within the BDP CAG,
however further data was required before realistic analysis could be made, a report would be brought back to the next meeting. Dr Jane Sayer explained that initiatives around violence were being conducted within River House with the introduction of a system that worked on improving communication and risk assessment. Two wards were being piloted and both had achieved a reduction. This programme would be rolled out across the Trust over the year.

The Board of Directors noted the reports.

BOD 60/13 HRG COSTING PAPER
Tim Greenwood introduced the report which set out the approach that would be taken to calculate HRG costs for the 2012/13 return, for submission in July 2013. The Trust would have to declare how much clinical input had been undertaken. Dr Martin Baggaley explained that AMH services were using this model and were receiving better data as a consequence.

The Board of Directors approved the approach to HRG costing.

BOD 61/13 FINANCE REPORT – MONTH 1
Tim Greenwood explained that the Trust was reporting a £1.4m variance from plan, if this variance was to continue a low 2 FRR rating would be achieved in Q1 under the current rating system. It had been agreed to include support for Psychosis and B&DP CAGs, and it was proposed that the Executive Directors work closely with the CAGs to bring forward a more detailed analysis of their positions and recovery actions plans for consideration at the June Board meeting.

Action: CAGs/Executive Directors.

Nursing costs were overspent by £307k within month 1 despite changes to budgets resulting from the business planning process. Dr Jane Sayer reported that work had taken place with some of these wards where there had been a correlation between financial and quality concerns, however closer inspection would be required. Discussions had taken place around identifying wards and how to intervene to support turn around.

Tim Greenwood explained that a meeting had taken place regarding the Specialist Commissioner Contract which was yet to be agreed, the gap was currently around £4m.

The Board of Directors noted the report.

BOD 62/13 ACTING CHIEF EXECUTIVE REPORT
Gus Heafield explained that the Government had now published the Care Bill which would be presented to Parliament.

A reorganisation of psychology and psychotherapy was being proposed that would integrate the two professional groups into a single structure. The new structure would be a simpler and leaner structure releasing a cost saving and allowing resources to be deployed more effectively.

The Board of Directors noted the report.
BOD 63/13 MEMBERS COUNCIL UPDATE
Noel Urwin explained that a paper proposing a number of changes to the FT Consultation would be considered at the June meeting of the Members’ Council and Board of Directors.

The process to hold by-elections to fill the current ten vacancies would commence imminently and conclude on the 26th July. It was important that as many members across all the relevant constituencies were encouraged to put their names forward for election.

The Annual Plan and Strategy group had met which provided an opportunity for an update and comment on the development of the Annual Plan. Likewise comments had been made as the Quality Account was being developed.

The Board of Directors noted the report.

BOD 64/13 AUDIT COMMITTEE ANNUAL REPORT AND REPORT TO MEMBERS COUNCIL
Gus Heafield explained that a special meeting had been held last week. Both internal and external Audit had reviewed the annual report and figures and were satisfied. An updated version of the Annual Report would be circulated to Board Members.

The Audit committee flagged some areas for attention which included:

- Competitive marketing/benchmarking
- Estates Department management issues
- Planning and risk management
- The impact of the KHP process

External Audit had also flagged an issue relating to the exemptions applied by the Trust in calculating the “Access to crisis interventions team” performance indicator.

The Board of Directors noted the report.

BOD 65/13 DIRECTOR’S REPORTS

- Kumar Jacob – reported that the new Maudsley Learning Centre would be opening on the 3rd June 2013. It offered flexible learning space spread over seven floors, with state of the art AV and communications facilities. The project had been on time and within budget.

- Gus Heafield – reported that at following a recent visit to Gresham One, he had been very impressed with the way the team had dealt with challenges, and the progress and the ambition of the team.

- Madeliene Long - reported that she had attended the NHS Chair’s Forum where they had visited NIHR Oxford Biomedical Research Centre facilities at the John Radcliff Hospital Oxford University Hospital NHS Trust.

BOD 66/13 FORWARD PLANNERS

Page 4 of 5
The Forward planner was noted.

**BOD 67/13 ANY OTHER BUSINESS**
No any other business was considered.

**BOD 68/13 MOTION TO EXCLUDE THE PRESS AND PUBLIC**
The Board of Directors agreed that representatives of the press and other members of the public be excluded from the remainder of the meeting having regard to the confidential nature of the business to be transacted, publicity on which would be prejudicial to the public interest (Section 1(2) Public bodies (Admission to Meetings) Act 1960.

The date of the next meeting will be: **Tuesday, 25th June 2013 – 3:00pm Boardroom, Maudsley Hospital, Denmark Hill, London, SE5 8AZ**

Chair
MINUTES OF THE
SERVICE QUALITY IMPROVEMENT
SUB-COMMITTEE OF THE TRUST BOARD OF DIRECTORS

HELD ON: 28th MAY 2013 at 9:00AM – 11AM

AT: Boardroom, Maudsley Hospital

Present:
Harriet Hall (Chair) Non-Executive Director (HH)
Patricia Connell-Julien Non-Executive Director (PCJ)
Gus Heafield Acting Chief Executive (GH)
Martin Baggaley Medical Director (MB)
Jane Sayer Interim Director of Nursing & Education (JS)
Zoë Reed Director Strategy & Business Development (ZR)
Jenny Goody (Secretary) Interim Governance Manager (JG)
Julie Jones (Minutes) PA to Director of Finance & Corporate Governance (JJ)

In Attendance (for item 5):
Kerry Tauxe Clinical Audit Project Officer (KT)

Apologies:
Nick Dawe Interim Director of Finance & Corporate Governance (ND)
Cliff Bean Deputy Director of Patient Safety & Assurance (CB)
Rosie Peregrine-Jones Clinical Audit & Effectiveness Manager (RPJ)
<table>
<thead>
<tr>
<th>Item</th>
<th>Business Item</th>
<th>Action by</th>
<th>Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.</td>
<td>Apologies</td>
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<td></td>
<td>As received above.</td>
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<td>2.</td>
<td>Declarations of interest / notifications of any other business</td>
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<td></td>
<td>No declarations of interest or notification of any other business were received.</td>
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<td>3.</td>
<td>Minutes of SQISC Meeting on 26th February 2013</td>
<td>JG</td>
<td>Jul-13</td>
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<td></td>
<td>The minutes were agreed as an accurate record.</td>
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<td>Matters arising: JG reported that MB’s concerns relating to the management of Estates &amp; Facilities being fit for purposes have also been identified by the Audit Committee, who have commissioned an update report that will be presented to their meeting in June 2013.</td>
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<td><strong>Action:</strong> report back on the management of Estates &amp; Facilities after the June Audit Committee.</td>
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<td>Date of next meeting: It is proving difficult to identify a suitable date in late Aug / early Sept, and so it was agreed to revert to the original Board day (23 July) for the next meeting of the SQISC. GH suggested that the committee should consider meeting bi-monthly in future, and it was later suggested that an additional date be set for late September.</td>
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<td>4.</td>
<td>Action Point Tracker: Outstanding Actions &amp; Closures</td>
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<td>The actions shaded green have been addressed since the last meeting and it was agreed that these could be closed.</td>
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<td>An update was given on the following outstanding actions:</td>
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<td><strong>Action 39:</strong> CB is actively working with Communications to disseminate the Quality Improvement message; a communication has been drafted and is awaiting sign off before being published; on-going.</td>
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<td><strong>Action 44:</strong> A draft dashboard was presented to the meeting under AOB but it was agreed that further clarification and discussion is required when CB is present; on-going.</td>
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<td><strong>Action 49:</strong> On-going.</td>
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<td><strong>Action 50:</strong> Deferred until the next meeting.</td>
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<td><strong>Action 51:</strong> Work is underway to review the Trust’s compliance with Monitor’s Quality Governance Framework, discussed in detail under agenda item 10.</td>
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**QUALITY IMPROVEMENT**

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<thead>
<tr>
<th>Item</th>
<th>Business Item</th>
<th>Action by</th>
<th>Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>10.</td>
<td>Quality Review</td>
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<td>HH introduced this item by outlining her concerns relating to her role as a Non-Executive Director (NED) in relation to quality: how can she be assured that the services SLaM provides meet the quality requirements of regulators, that they meet our own basic standards, that there are no hidden problems and that our aspirations to be World Class are meaningful. JS outlined the current mechanisms for monitoring quality and the proposals to expand these to address Monitor’s Quality Governance Framework and the Francis Report. It was agreed that Monitor’s Quality Governance Framework would provide a good starting point – aspiring FT’s undergo a two-day assessment by Monitor and MB suggested that SLaM should carry out a similar exercise. It was agreed that CB should be asked to arrange an internal but formal review of the Trust’s compliance with the Quality Governance Framework. It was suggested that a gap analysis should be undertaken first; to identify and address areas of known non-compliance before the formal assessment</td>
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Item | Business Item | Action by | Date
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takes place.

**Action:** Undertake a gap analysis of the Trust's compliance with Monitor’s Quality Governance Framework.

**Action:** Undertake a formal assessment of the Trust's compliance with Monitor’s Quality Governance Framework.

JS commented that HH's questions were particularly helpful in putting quality issues into context and highlighted the need to link everything that the Trust is doing together in a cohesive way. JS stated that the Quality Account doesn’t currently include workforce quality indicators or monitor achievement against all CQUIN targets, but these data are readily available and, together with the Quality Account data, could be gathered to produce an annual assurance report on data quality.

**Action:** Provide an annual assurance report on data quality.

ZR then presented a paper outlining a proposed Culture, Quality and Transformation Programme that aims to ensure that the recommendations within the Francis Report are addressed. The programme is based around the development of mutual, respectful relationships as described in the five key commitments (be caring, kind and polite; be prompt and value service users’ time; take time to listen to service users; be honest and direct with service users; do what you say you’re going to do), which are key to developing a compassionate culture. The key task is to ensure engagement with the programme, and ZR noted that appraisals under the new approach would be focusing on raising awareness of the five commitments to generate respect between members of staff and between staff and service users.

The next step will be to set up a working group to review the Trust’s compliance with the Francis Report recommendations, which will report back to the SQISC as a standing agenda item. The Francis Group would benefit from the involvement of a NED; HH offered to be involved in this group, but warned that her term of office will come to an end in December 2013.

JS then presented a paper on Building a Compassionate Culture, prepared by the Trust Head of Psychology, Alison Beck. There is robust evidence to suggest that organisational engagement results in more engaged staff, leading to a more compassionate culture. The staff survey is currently the only measure of staff engagement but, other than showing that community staff are less engaged, there is no way of drilling down to detailed information beyond CAG level. Work to improve staff engagement is progressing in many areas but there is no consistent approach; the Trust needs to apply a SMART approach to identify where engagement is working well and how to spread best practice, especially to areas where engagement is at its lowest. GH stressed the need for an integrated approach and suggested using all existing opportunities, such as Trust Induction, to spread the message.

HH asked how consultants will be involved in the plan to embed a compassionate culture; MB responded that consultants understand the principle of a compassionate culture and need to be involved in ensuring a Trust-wide understanding of what it means in practice. It was agreed that a sophisticated method of embedding and measuring compassion is required. PCJ commented that a classic change management approach is required, with different strategies for different groups.

GH requested an update in July, which should include practical examples of how the plan to embed a compassionate culture is being taken forward, expressed in terms of ‘patient quality’. HH suggested
starting with a finite task in an area where compassion has been identified as being low.

**Action:** Include practical examples of how the plan to embed a compassionate culture is being taken forward, in the Francis Report update at the next meeting.

ZR left the meeting at this point to attend another meeting.

## SCRUTINY & ASSURANCE

### 5. Clinical Audit

KT presented an overview of three recent clinical audits, to provide assurance relating to aspects of the Quality Governance Framework as requested by HH at the February meeting of the SQISC (Action 52).

There was some discussion about whether the email group ‘all staff clinical’ actually captured all clinical staff; KT will pursue the issue of out-of-date distribution lists with ICT and consider ways of ensuring that audit samples are fit for purpose.

The presentation was backed up by a detailed report of the clinical audits undertaken in 2012-13 Q4 and 2013-14 Q1; HH questioned why only 57% (4/7) of cases discharged from inpatient services had follow-up within 7 days, when the stated figure to Monitor is 100%. JS responded that the 100% target only relates to patients on CPA; it is unclear whether this was the case for the 3 patients that were not followed up in this audit. MB added that follow-up is arranged for all discharged patients, but it is not always possible to carry this out, especially with patients who do not stay within SLaM services. HH questioned whether what is declared to Monitor is backed up by clinical audit; GH responded that GH Grant Thornton review all submissions to Monitor and provide assurance that the figures are correct.

**Action:** Ask the Clinical Audit team to ensure that audits are aligned to specific national targets and use the same definitions as Monitor wherever possible.

HH thanked KT for her knowledgeable and informative presentation.

### 6. Assurance Framework Review – Strategic Risks

JG presented the principal risks that currently threaten the achievement of the Trust’s objectives in 2013/14, with proposed risk ratings and key mitigating actions, which was discussed and approved by the April meeting of the Board and Directors. JG pointed out the new additions to the report: sources of assurance and metrics to evidence progress against each action. The next step is to ensure that the key actions identified by the Trust Executive are reasonable from a CAG and Directorate perspective and begin to understand how they are progressing. CAGs have been asked to provide this information by the end of May-13.

Further sources of assurance were proposed, especially relating to the first three Service Quality risks that this committee will focus on in future meetings.

### 7. Corporate Risk Log Review – Operational Service Quality Risks

JG presented the Service Quality risks within the Corporate Risk Log (CRL), stating that the Trust is reverting to the two-tier approach of a few high-level strategic risks (discussed under agenda item 6) underpinned by the more detailed operational risks that will comprise the CRL. The operational risks within the existing Assurance Framework will be reviewed to ensure that the CRL contains only current concerns; risks that do not appear on CAG RARs will be
transferred back to infrastructure directorate RARs, with updates noted by the Risk Management Committee.

The following risks were discussed in detail:

**TW12 (Suicide / Homicide):** HH asked for the assurance that this risk is currently under control to be made clearer, with reference to benchmarking against other MH Trusts. The current risk rating now equals the target and no further specific actions have been identified to mitigate it further, and so it was agreed that it can be transferred to the ‘inherent’ risk category that will be reviewed annually.

**TW52 (Supervised Confinement Rooms):** PCJ suggested that this should be expanded to include other aspects of confinement, such as the length of time a patient is confined.

MB suggested that a new risk relating to police involvement / restraint should be added to the CRL, after a recent BLI and national events and the possible high impact to the Trust’s reputation.

Another risk relating to the quality of services provided by external suppliers was also raised, specifically in relation to placing overspill patients into the Dene.

**Action:** Liaise with MB to confirm the details of the two new risks to be added to the CRL.

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**EXTERNAL QUALITY REPORTING**

8. **Quality Account**

JS presented the 2012-13 Quality Account, which has been out for consultation and audited by both Grant Thornton and Deloitte’s; some minor changes are still required before it can be placed on the NHS Choices website. HH commented on the following:

- that Clinical Effectiveness target 4 re smoking would be better placed under Patient Safety;
- that Clinical Effectiveness target 5 re friends and family tests would be better placed under Patient Experience;
- that Part 3 (statements of assurance) should refer to the Board reviewing all relevant data rather than all data;
- that Safeguarding Adults should be explained;
- that the non-participation in the PICU project, shaded red, portrays a negative message, whereas the Trust’s overall participation in National Quality Improvement Projects is very positive; it was suggested that the shading or the whole row be removed;
- that it is not clear whether the 111 reported deaths include those due to natural causes;
- that the 2012/13 target for reducing violent incidents is stated as 12.5% whereas the Quality Strategy quotes a 3-year target of 25%; the Quality Account needs to distinguish between these two targets.

GH commented that the Delayed Discharges national indicator should be changed from 3.3% to 3.8%, after discussion with the Trust’s auditors.

**Action:** Pass the comments of the SQISC Chair on to the Board review of the Quality Account later in the day and update the document accordingly.

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**QUALITY IMPROVEMENT**

9. **Quality Programme Delivery and Assurance Group**

MB gave a brief update on the work of the Quality Programme Delivery
and Assurance Group (QPDAG), stating that the membership of the meeting has been expanded to include all relevant areas and that substantial progress is being made. 
This update was backed up by a précis of the Group’s minutes, which provides a summary of the work undertaken at their last meeting. 
The report was noted by the committee.

**RISK IDENTIFICATION**

11. **Quality Issues Report**
JG presented a brief report of quality issues identified by the Trust leads for serious incidents, complaints, claims and inquests. HH commented that this is a useful report, although no significant new risks were identified. 
The report was noted by the committee.

12. **Sub-committee Escalation Reports**
The Risk Management Committee reported two issues, relating to sprinklers and non-collapsible curtain rails, that were raised at their last meeting and passed to Estates & Facilities for remedial action. This was noted by the committee. 
The Quality Governance Committee submitted the minutes of their meeting held on 13 March 2013, which were noted by the committee.

13. **Feedback to Board of Directors & Audit Committee**
It was agreed that no specific Service Quality issues need be reported to the Board at this time. 
The Audit Committee will receive a highlight report comprising a précis of the meeting minutes for information.

14. **Feedback to RMC and QGC**
It was agreed that there were no urgent issues that need to be fed back to the Risk Management or Quality Governance committees at this time; they will be provided with a highlight report comprising a précis of the meeting minutes for information.

15. **Forward Planner**
The Forward Planner for 2013 was noted by the committee.

16. **Any Other Business**
No other items were raised.

17. **Dates of 2013 meetings**
   - 26 February
   - 28 May
   - 23 July
   - ?? September
   - 26 November
RATIFICATION FORM

Tuesday, 18 June 2013

To: Alison Baker

From: Medical HR

<table>
<thead>
<tr>
<th>Name</th>
<th>Dr Stephen Miller</th>
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<tbody>
<tr>
<td>Title/Post</td>
<td>Consultant Psychotherapist</td>
</tr>
<tr>
<td>Base</td>
<td>Bethlem Royal Hospital/Community Locations in Croydon</td>
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<tr>
<td>Speciality</td>
<td>Personality Disorder Service</td>
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<tr>
<td>Qualifications</td>
<td>MB ChB, MRC Psych, CCST in Psychotherapy, MD, M.Inst. Psychoanal</td>
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<td>Previous Trust</td>
<td>SW London &amp; St George’s Mental Health NHS Trust</td>
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Copy to: Dr Martin Baggaley
TRUST BOARD OF DIRECTORS – SUMMARY REPORT

Date of Board meeting: 25th June 2013

Name of Report: KHP Board Update

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

Author: 

Approved by: (name of Exec Member)

Presented by: Professor Sir Robert Lechler

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

Action required: To receive the presentation

Recommendations to the Board: The presentation is for information.

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

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

Equality & Diversity and Public & Patient Involvement Implications: A key purpose of King’s Health Partners is to improve the health and wellbeing of local people. In developing their strategies, the CAGs are specifically required to state how they will address the health inequalities reflected in the “heat map”. This of necessity requires that service users and their carers are actively involved in their own care and the developments within services. It also requires that no service user receives less favourable services or outcomes as a result of their ethnicity, gender, disability, sexuality, faith or age.
Date of Board meeting: 25 June 2013

Name of Report: R&D Report
(a) R&D annual report to the Board of Directors
(b) R&D Operational Capability Statement

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

Author: Tom Craig / Gill Dale

Presented by: Tom Craig

Purpose of the report:
1. To provide the Board with an update on R&D activities and achievements
2. To seek the Board’s approval for the SLaM’s R&D Organisational Capability Statement (updated)

Action required:
1. To note for information
2. To approve the updated R&D Organisational Capability Statement

Recommendations to the Board:
To receive the report and approve the R&D Organisational Capability Statement

Relationship with the Assurance Framework (Risks, Controls and Assurance):
Objective 8 of the Assurance Framework (financial) - maximising potential R&D income sources.
Compliance with Standards for Better Health – C12 in Domain 3, Research Governance.

Summary of Financial and Legal Implications:
Update to Board on financial impact of national research strategy

Equality & Diversity and Public & Patient Involvement Implications:
Key strategic objective for R&D is the reduction of discrimination
R&D Update
SLaM Board Of Directors

25 June 2013

Tom Craig
Director of R&D
Gill Dale
Director of Research Quality
Impact of our Research: Highlights

Examples of SLaM/IoP research translated into SLaM services and beyond:

- **Psychosis** – CBT for medication-unresponsive psychosis
- **Chronic Fatigue Syndrome** – CBT and graded exercise therapy
- **Eating disorders** – Cognitive Remediation Therapy – clinician’s guides, therapist training, self help books, resources for teachers; Maudsley Family Therapy for Anorexia Nervosa
The Institute of Psychiatry

NIHR Biomedical Research Centre / Biomedical Research Unit (Dementia)

• CRIS system now being implemented in Cambridge & Peterborough, Camden and Islington, West London and Oxford.
  – Funding from NIHR; led by Mike Denis and Simon Lovestone.
  – More than 25 publications already using CRIS.
  – Major opportunity for SLaM to lead collaborative projects across mental health Trusts in SE England

• Athena Swan/Women in Science is a major priority. BRC/U has agreed, and an implementation plan is being established for:
  – Deputies for all cluster leads to be appointed
  – Junior representation on Executive committee
  – Funding to support career break returnees

• Multiple dementia trials now funded in dementia
  – both commercial and non-commercial
  – these trials successfully using CRF at King’s

• Engagement Day 10 July
  – Focussing on trials and informatics
  – Opportunity to engage clinicians in generating use-cases for CRIS and MyHealthLocker
New research programmes
- examples

• New NIHR Programme grants:
  – Emily Simonoff - Improving outcomes for people with autism spectrum disorders by reducing mental health problems
  – Louise Howard – The effectiveness and cost-effectiveness of perinatal mental health services
  – Rob Howard – Towards an evidence-based clinical management of visual hallucinations: prevalence, prognosis, impact and pathophysiology

• Other
  – Tom Craig & Philippa Garety - Computer assisted therapy for ‘voices’ (AVATAR Therapy RCT).
New Research: AVATAR Therapy

Avatar Therapy Hardware Configuration

- Clinician
- Client
- Room partition
- M-Audio AV3012
- Sony ECFSF8
- Behringer UCA-222
- Behringer UCA-222
- PreSonus DT-236-PRO

Client Audio

Therapist Audio

Therapist Controls

South London and Maudsley NHS Foundation Trust
The NHS R&D Funding Landscape

• **NOW** - The National Institute for Health Research (NIHR) - umbrella organisation funded (since 2006) through DH to improve health and wealth of the nation through research

• **BEFORE** - Pre-NIHR, NHS R&D infrastructure funding was allocated to NHS organisations as a block grant: the R&D Levy or ‘Culyer Funding’
History: SLaM R&D funding position pre-NIHR

- Large R&D Levy: £26m (mostly infrastructure / NHS support costs)
- Funding intertwined with clinical services to underpin cost of supporting research
Now: SLaM R&D Funding under NIHR

• Success from outset with NIHR Programme Grants

• Secured NIHR Biomedical Research Centre (recent second 5 year funding plus Biomedical Research Unit in Dementia)

• **BUT** – over all reduction in infrastructure / NHS support funding
Current NIHR infrastructure / support funding

- NIHR BRC / BRU include some infrastructure support
- Patients recruited under NIHR Portfolio grants generate NHS support funding through the Comprehensive Local Research Networks
- NIHR grants, BRC/BRU and NIHR Senior Investigators generate Research Capability Funding (RCF) (previously called Flexibility and Sustainability Funding, FSF)
# SLaM NIHR income (NHS Support costs and infrastructure / overheads)

<table>
<thead>
<tr>
<th>NIHR Scheme</th>
<th>NIHR income 2011/12 (k)</th>
<th>NIHR income 2012/13 (k)</th>
<th>NIHR income 2013/14 (k)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Biomedical Research Centre / Biomedical Research Unit</td>
<td>2,752</td>
<td>1,749</td>
<td>2,134</td>
</tr>
<tr>
<td>Research Capability Funding (previously Flexibility &amp; Sustainability Funding)</td>
<td>4,212</td>
<td>4,571</td>
<td>3,878</td>
</tr>
<tr>
<td>Comprehensive Local Research Network Funding</td>
<td>2,080</td>
<td>1,881</td>
<td>1,693</td>
</tr>
<tr>
<td>Overheads from NIHR grants</td>
<td>519</td>
<td>398</td>
<td>288</td>
</tr>
<tr>
<td><strong>TOTAL NHS SUPPORT COSTS AND OVERHEADS</strong></td>
<td><strong>9,563</strong></td>
<td><strong>8,599</strong></td>
<td><strong>7,993</strong></td>
</tr>
</tbody>
</table>
SLaM R&D Funding and CAGs

R&D funding is distributed to CAGs on the basis of:

- CLRN money on patients recruited
- RCF funding based on the total amount of other NIHR income received and on the number of NIHR Senior Investigators

Recruitment is reducing due to high recruiting grants ending; new grants in pipeline
Consent for Consent (C4C)

- Continuing programme
- Modifying and simplifying process
- Expanding the team to cover more of the CAGS
- Top down bottom up implementation
- No difference in rates by ethnicity
- Used successfully to recruit to studies

1244 screened, of which 895 ‘yes’
Performance metrics

- NIHR contract benchmarks – initiation and delivery
  - 70 day target
    - Time between receipt by R&D of Valid Research Application and first patient recruited

- NIHR Clinical Research Network objectives
  - Local R&D approval times
New opportunities / changes

- AHSN - Academic Health Sciences Network
- CLAHRC – Collaborations for Leadership in Applied Health Research and Care
- Clinical Research Facility
- New clinical settings as research environments e.g. IAPT
- Changes to NIHR Clinical Research networks (CLRN, MHRN)
# Organisation R&D Management Arrangements

## Information on key contacts

<table>
<thead>
<tr>
<th>Contact 1:</th>
<th>R&amp;D Director (with responsibility for reporting on R&amp;D to the Organisation Board)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Name</td>
<td>Professor Tom Craig</td>
</tr>
<tr>
<td>Contact Number:</td>
<td>020 7848 0251</td>
</tr>
<tr>
<td>Contact Email:</td>
<td><a href="mailto:gill.dale@kcl.ac.uk">gill.dale@kcl.ac.uk</a></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Contact 2:</th>
<th>Director of Research Quality</th>
</tr>
</thead>
<tbody>
<tr>
<td>Name</td>
<td>Dr Gill Dale</td>
</tr>
<tr>
<td>Contact Number:</td>
<td>020 7848 0675</td>
</tr>
<tr>
<td>Contact Email:</td>
<td><a href="mailto:gill.dale@kcl.ac.uk">gill.dale@kcl.ac.uk</a></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Contact 3:</th>
<th>Biomedical Research Centre Manager</th>
</tr>
</thead>
<tbody>
<tr>
<td>Name</td>
<td>Dr Saliha Afzal</td>
</tr>
<tr>
<td>Contact Number:</td>
<td>020 7848 5485</td>
</tr>
<tr>
<td>Contact Email:</td>
<td><a href="mailto:saliha.afzal@kcl.ac.uk">saliha.afzal@kcl.ac.uk</a></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Contact 4:</th>
<th>R&amp;D Contracts Manager</th>
</tr>
</thead>
<tbody>
<tr>
<td>Name</td>
<td>Mr Krean Naicker</td>
</tr>
<tr>
<td>Contact Number:</td>
<td>7972660605</td>
</tr>
<tr>
<td>Contact Email:</td>
<td><a href="mailto:krean.naicker@kcl.ac.uk">krean.naicker@kcl.ac.uk</a></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Contact 5:</th>
<th>Manager, Clinical Trials Unit</th>
</tr>
</thead>
<tbody>
<tr>
<td>Name</td>
<td>Ms Jackie Powell</td>
</tr>
<tr>
<td>Contact Number:</td>
<td>020 7188 8330</td>
</tr>
<tr>
<td>Contact Email:</td>
<td><a href="mailto:jackie.powell@kcl.ac.uk">jackie.powell@kcl.ac.uk</a></td>
</tr>
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</table>

<table>
<thead>
<tr>
<th>Contact 6:</th>
<th>Director, King’s Health Partners Clinical Trials Office</th>
</tr>
</thead>
<tbody>
<tr>
<td>Name</td>
<td>Ms Jackie Powell</td>
</tr>
<tr>
<td>Contact Number:</td>
<td>020 7188 8330</td>
</tr>
<tr>
<td>Contact Email:</td>
<td><a href="mailto:jackie.powell@kcl.ac.uk">jackie.powell@kcl.ac.uk</a></td>
</tr>
</tbody>
</table>

## Organisation Details

- **Name of Organisation**: South London and Maudsley NHS Foundation Trust (SLaM)
- **Director of Research Quality**: Dr Gill Dale

## Key Contact Details e.g. Research Governance Lead, NHS Permissions Signatory contact details

<table>
<thead>
<tr>
<th>Name</th>
<th>Contact Number</th>
<th>Contact Email</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ms Jenny Liebscher</td>
<td>020 7848 0675</td>
<td><a href="mailto:gill.dale@kcl.ac.uk">gill.dale@kcl.ac.uk</a></td>
</tr>
<tr>
<td>Ms Joanna Jenner</td>
<td>020 7848 0270</td>
<td><a href="mailto:joanna.jenner@kcl.ac.uk">joanna.jenner@kcl.ac.uk</a></td>
</tr>
<tr>
<td>Dr Saliha Afzal</td>
<td>020 7848 5485</td>
<td><a href="mailto:saliha.afzal@kcl.ac.uk">saliha.afzal@kcl.ac.uk</a></td>
</tr>
<tr>
<td>Mr Krean Naicker</td>
<td>7972660605</td>
<td><a href="mailto:krean.naicker@kcl.ac.uk">krean.naicker@kcl.ac.uk</a></td>
</tr>
</tbody>
</table>
### Information on staffing of the R&D Office

<table>
<thead>
<tr>
<th>R&amp;D Team</th>
<th>Whole Time Equivalent</th>
<th>Comments</th>
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</thead>
<tbody>
<tr>
<td>Director of Research Quality / Head of Joint R&amp;D Office</td>
<td>1</td>
<td>Jointly funded and joint role between NHS Trust and university</td>
</tr>
<tr>
<td>R&amp;D Governance Delivery Manager</td>
<td>1</td>
<td></td>
</tr>
<tr>
<td>Research Governance Facilitator</td>
<td>1</td>
<td></td>
</tr>
<tr>
<td>R&amp;D Funding Manager</td>
<td>1</td>
<td></td>
</tr>
<tr>
<td>R&amp;D Administrative</td>
<td>1</td>
<td></td>
</tr>
<tr>
<td>Biomedical Research Centre Manager</td>
<td>1</td>
<td></td>
</tr>
<tr>
<td>R&amp;D Contracts Manager</td>
<td>1</td>
<td></td>
</tr>
</tbody>
</table>

Add further lines as required

### Information on reporting structure in organisation (include information on any relevant committees, for example, a Clinical Research Board / Research Committee / Steering Committee.)

The Director of Research Quality is Head of the Joint R&D Office of the South London and Maudsley NHS NHS Foundation Trust (SLaM) and the Institute of Psychiatry (IoP), King's College London and reports jointly to the R&D Director of SLaM and the IoP Vice Dean (Research). For the Trust the R&D Director has a direct reporting line to the Trust Chief Executive and Trust Board of Directors. All staff within the R&D Office report to the Director of Research Quality with the exception of the Biomedical Research Centre (BRC) Manager who reports to the Director of the BRC.

### Information on Research Networks supporting/working with the Organisation.

<table>
<thead>
<tr>
<th>Research Networks</th>
<th>Role/relationship of the Research Network: eg host Organisation</th>
</tr>
</thead>
<tbody>
<tr>
<td>London South Comprehensive Local Research Network (CLRN)</td>
<td>Member organisation</td>
</tr>
<tr>
<td>Mental Health Research Network (MHRN)</td>
<td>SLaM hosts the South London and South East MHRN Hub; Institute of Psychiatry is joint host of MHRN nationally with University of Manchester</td>
</tr>
</tbody>
</table>

Add further lines as required

### Information on collaborations and partnerships for research activity (e.g. BRC, BRU, Other NHS Organisations, Higher Education Institutes, Industry)

<table>
<thead>
<tr>
<th>Organisation Name</th>
<th>Details of Collaboration / Partnership (eg University/Organisation Joint Office, external provider of pathology services to Organisation, etc, effective dates)</th>
<th>Contact Name</th>
<th>Email address</th>
<th>Contact Number</th>
</tr>
</thead>
<tbody>
<tr>
<td>King's Health Partners</td>
<td>Partner within Academic Health Sciences Centre <a href="http://www.kingshealthpartners.org">www.kingshealthpartners.org</a></td>
<td>Jill Lockett</td>
<td><a href="mailto:jill.lockett@kcl.ac.uk">jill.lockett@kcl.ac.uk</a></td>
<td></td>
</tr>
<tr>
<td>King's College London</td>
<td>Co-Partner within King's Health Partners</td>
<td>Keith Brennan</td>
<td><a href="mailto:keith.brennan@kcl.ac.uk">keith.brennan@kcl.ac.uk</a></td>
<td></td>
</tr>
</tbody>
</table>
### Organisation Study Capabilities

Information on the types of studies that can be supported by the Organisation to the relevant regulatory standards

#### Types of Studies Organisation has capabilities in (please tick applicable)

<table>
<thead>
<tr>
<th>Organisation</th>
<th>CTIMPs</th>
<th>Clinical Trial of a Medical Device</th>
<th>Other Clinical Studies</th>
<th>Human Tissue Samples Studies</th>
<th>Study Administering Questionnaires</th>
<th>Qualitative Study</th>
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</thead>
<tbody>
<tr>
<td>Sponsoring</td>
<td>All</td>
<td>All</td>
<td>All</td>
<td>All</td>
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<tr>
<td>Participating</td>
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<td>All</td>
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<td>All</td>
</tr>
<tr>
<td>Participant Identification Centre</td>
<td>All</td>
<td>All</td>
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<td>All</td>
<td>All</td>
</tr>
</tbody>
</table>

### Licence Details

<table>
<thead>
<tr>
<th>Licence Name</th>
<th>Licence Details</th>
<th>Licence Start Date (if applicable)</th>
<th>Licence End Date (if applicable)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Human Tissue Authority Licence held by University Partner (IoP, King's College London)</td>
<td>London Neurodegenerative Diseases Brain Bank</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

### Organisation Services

Information on key clinical services contacts and facilities/equipment which may be used in studies for supporting R&D governance decisions across the organisation.

#### Clinical Service Departments

<table>
<thead>
<tr>
<th>Service Department</th>
<th>Specialist facilities that may be provided (eg number/type of scanners)</th>
<th>Contact Name within Service Department</th>
<th>Contact email</th>
<th>Contact number</th>
<th>Details of any internal agreement templates</th>
</tr>
</thead>
<tbody>
<tr>
<td>Pathology</td>
<td>Externally provided by King's College Hospital NHS Foundation Trust</td>
<td>Jan Teahon</td>
<td><a href="mailto:jan.teahon@kch.nhs.uk">jan.teahon@kch.nhs.uk</a></td>
<td>020 3299 1742</td>
<td></td>
</tr>
<tr>
<td>Radiology - Neuroimaging</td>
<td>SLaM provides a full range of neuroradiographic imaging services, including Plain Radiography, Computerised Tomography (CT), and Magnetic Resonance Imaging (MRI). For research studies, the Centre for Neuroimaging Studies houses a dedicated GE 3T Excite II MRI scanner (which is also made available for clinical and advanced clinical scanning, where appropriate). Additionally, there is a GE SIGNA 1.5T neuro-optimised MR system. Both machines (along with the clinical 1.5T scanner) are capable of performing functional, spectroscopic, anatomical and pathological mapping techniques. Gay Coombes</td>
<td>Gay Coombes</td>
<td><a href="mailto:gay.coombes@slam.nhs.uk">gay.coombes@slam.nhs.uk</a></td>
<td>0203 228 3005</td>
<td></td>
</tr>
<tr>
<td>Pharmacy</td>
<td>NHS Hospital Pharmacy</td>
<td>David Taylor</td>
<td><a href="mailto:david.taylor@slam.nhs.uk">david.taylor@slam.nhs.uk</a></td>
<td>0203 228 5040</td>
<td></td>
</tr>
</tbody>
</table>
Information on key management contacts for supporting R&D governance decisions across the organisation.

<table>
<thead>
<tr>
<th>Department</th>
<th>Specialist services that may be provided</th>
<th>Contact Name within Service Department</th>
<th>Contact email</th>
<th>Contact number</th>
<th>Details of any internal agreement templates</th>
</tr>
</thead>
<tbody>
<tr>
<td>Archiving</td>
<td></td>
<td>J. Michael Phillips</td>
<td>j <a href="mailto:michael.phillips@slam.nhs.uk">michael.phillips@slam.nhs.uk</a></td>
<td>0203 228 4307</td>
<td></td>
</tr>
<tr>
<td>Contracts</td>
<td></td>
<td>Julia Gannon</td>
<td><a href="mailto:julia.gannon@slam.nhs.uk">julia.gannon@slam.nhs.uk</a></td>
<td>0203 228 1678</td>
<td></td>
</tr>
<tr>
<td>Finance</td>
<td></td>
<td>Deborah Heron</td>
<td><a href="mailto:deborah.heron@slam.nhs.uk">deborah.heron@slam.nhs.uk</a></td>
<td>0203 228 4741</td>
<td></td>
</tr>
<tr>
<td>Biomedical Research Centre (BRC) Nucleus</td>
<td>Specialists in bioinformatics, statistics, biobanking, proteomics and neuroimaging to develop innovative analytical and biomedical projects to support translational research. <a href="http://www.slam.nhs.uk/about-us/biomedical-research-centre/about-the-brc/core-facilities/brc-nucleus.aspx">http://www.slam.nhs.uk/about-us/biomedical-research-centre/about-the-brc/core-facilities/brc-nucleus.aspx</a></td>
<td>Saliha Afzal</td>
<td><a href="mailto:saliha.afzal@kcl.ac.uk">saliha.afzal@kcl.ac.uk</a></td>
<td>020 7848 5485</td>
<td></td>
</tr>
<tr>
<td>Information Technology - CRIS</td>
<td>Case Register Interactive Search (CRIS) - anonymised information extracted from SLaM's electronic patient records system by authorised researchers. <a href="http://www.slam.nhs.uk/about-us/biomedical-research-centre/about-the-brc/core-facilities/case-register-interactive-search-(cris)-system.aspx">http://www.slam.nhs.uk/about-us/biomedical-research-centre/about-the-brc/core-facilities/case-register-interactive-search-(cris)-system.aspx</a></td>
<td>Mike Denis</td>
<td><a href="mailto:mike.denis@slam.nhs.uk">mike.denis@slam.nhs.uk</a></td>
<td></td>
<td></td>
</tr>
<tr>
<td>NHR/Wellcome Trust King's Clinical Research Facility</td>
<td>The CRF is the first of its kind in the world to be specifically designed to support mental health and neurosciences clinical trials. It also enables us to further develop our pioneering research in specialist fields including haematology-oncology, cardiovascular medicine and diabetes. The CRF includes: • An Experimental Medicine Facility, comprising the latest neuroimaging and EEG facilities to study the brain in action, a virtual reality behaviour suite and an intensive care unit facility for patients with brain injury. • The largest Cell Therapy Unit in Europe, in either academia or industry. This will enable us to expand our world leading programme of work, demonstrated by the fact that we were the first centre to treat liver failure using cell therapy. • A Clinical Trials Unit; providing a state of the art facility for commercially sponsored trials.</td>
<td>Elke Giemza</td>
<td><a href="mailto:elke.giemza@nhs.net">elke.giemza@nhs.net</a></td>
<td>020 3299 1850</td>
<td></td>
</tr>
<tr>
<td>Legal</td>
<td></td>
<td>Paul Bellerby</td>
<td><a href="mailto:paul.bellerby@slam.nhs.uk">paul.bellerby@slam.nhs.uk</a></td>
<td>0203 228 4006</td>
<td></td>
</tr>
<tr>
<td>Personnel</td>
<td></td>
<td>Michael Kelly</td>
<td><a href="mailto:michael.kelly@slam.nhs.uk">michael.kelly@slam.nhs.uk</a></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Clinical Trials Unit</td>
<td>Randomisation Service; an Online Data Capture and Management Service; a Trial Statistician Service; Trial Management and Data Management support. <a href="http://www.ipp.kcl.ac.uk/departments?locator=405">http://www.ipp.kcl.ac.uk/departments?locator=405</a></td>
<td>Caroline Murphy</td>
<td><a href="mailto:caroline.murphy@kcl.ac.uk">caroline.murphy@kcl.ac.uk</a></td>
<td>0207 848 5273</td>
<td></td>
</tr>
<tr>
<td>King's Health Partners Clinical Trials Office</td>
<td>Commercial contract management; non-commercial management of Sponsor responsibilities of partners. <a href="http://www.jcto.co.uk/index.html">http://www.jcto.co.uk/index.html</a></td>
<td>Jackie Powell</td>
<td><a href="mailto:jackie.powell@kcl.ac.uk">jackie.powell@kcl.ac.uk</a></td>
<td>0207 188 9339</td>
<td></td>
</tr>
</tbody>
</table>

**Organisation R&D Interests**

Information on the areas of research interest to the Organisation

<table>
<thead>
<tr>
<th>Area of Interest</th>
<th>Details</th>
<th>Contact Name</th>
<th>Contact Email</th>
<th>Contact Number</th>
</tr>
</thead>
<tbody>
<tr>
<td>Design and Analysis</td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>Clinical Trials</td>
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<tr>
<td>Neurology</td>
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<td>Psychiatry</td>
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<td>Health Economics</td>
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<tr>
<td>Neuroimaging</td>
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</tbody>
</table>

Go to top of document
### Mental Health: SLaM/IoP Clinical Academic Groups

- Child & Adolescent; Addictions; Mental Health of Older Adults and Dementia; Psychosis; Mood, Anxiety and Personality Disorder; Psychological Medicine; Behavioural & Developmental Psychiatry.

### Mental Health - translational research

<table>
<thead>
<tr>
<th>Specialty Group Membership (Local and National)</th>
</tr>
</thead>
<tbody>
<tr>
<td>National / Local</td>
</tr>
<tr>
<td>------------------</td>
</tr>
</tbody>
</table>

### Information on Local / National Specialty group membership within the Organisation which has been shared with the CLRN

<table>
<thead>
<tr>
<th>SOP Reference</th>
<th>SOP Title</th>
<th>Description of Planned Investment</th>
<th>Value of Investment</th>
<th>Indicative dates</th>
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<tr>
<td>1.0</td>
<td>2.0</td>
<td>3.0</td>
<td>4.0</td>
<td>5.0</td>
</tr>
</tbody>
</table>

### Organisation R&D Planning and Investments

<table>
<thead>
<tr>
<th>Planned Investment</th>
<th>Description of Planned Investment</th>
<th>Value of Investment</th>
<th>Indicative dates</th>
</tr>
</thead>
<tbody>
<tr>
<td>Area of Investment (e.g. Facilities, Training, Recruitment, Equipment etc.)</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

### Organisation R&D Standard Operating Procedures Register

The Joint SLaM/IoP Office is currently aligning its existing Standard Operating Procedures and practices with the NIHR RSS format. The following Standard Operating Procedures are in progress:

<table>
<thead>
<tr>
<th>Standard Operating Procedures</th>
<th>Valid from</th>
<th>Valid to</th>
</tr>
</thead>
<tbody>
<tr>
<td>NiHR Coordinated System for gaining NHS Permission (CSP)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Integrated Research Application System (IRAS)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>CTiMP trials</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Research Passport</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Add further lines as required.
Information on the processes used for managing Research Passports

The type of HR agreement required is assessed by the R&D Office in accordance with the principles of the Research in the NHS: HR Good Practice Resource Pack (http://www.nihr.ac.uk/systems/pages/systems_research_passports.aspx) as part of the R&D governance approval process at SLaM. Details on the R&D Office website at http://www.kcl.ac.uk/iop/research/office/index.aspx. The Research Passport process facilitates the issuing of either an honorary contract or letter of access for university researchers or NHS researchers as appropriate.

Information on the agreed Escalation Process to be used when R&D governance issues cannot be resolved through normal processes

Escalation Process

Issues would be discussed initially with the Director of Research Quality, which may be taken to the Director of R&D if further escalation is considered justified. Any suspected research governance breaches are investigated thoroughly by the R&D Office.

Planned and Actual Studies Register

The Joint SLaM/IoP office maintains a current list of planned and actual studies.

Other Information

For example, where can information be found about the publications and other outcomes of research which key staff led or collaborated in?

The Trust works in close collaboration with the Institute of Psychiatry (King's College London) - much of the collaborative research and research outputs are detailed on the IoP website at http://www.kcl.ac.uk/iop/index.aspx. Information about the SLaM/IoP NIHR Specialist Biomedical Research Centre for Mental Health is on the Trust website at http://brc.slam.nhs.uk/. SLaM is fully compliant with and is using national systems (IRAS and CSP) to manage these studies in proportion to risk. All of our NIHR Portfolio studies have been conducted under NIHR Topic Specific Networks, the majority of studies being under the Mental Health Research Network.
### TRUST BOARD OF DIRECTORS

#### SUMMARY REPORT

<table>
<thead>
<tr>
<th>Date of Board meeting:</th>
<th>30th June 2013</th>
</tr>
</thead>
<tbody>
<tr>
<td>Name of Report:</td>
<td>Service Quality Indicator Report and Exception Report on Infection Control Surveillance</td>
</tr>
<tr>
<td>Heading:</td>
<td>Quality</td>
</tr>
<tr>
<td>Author:</td>
<td>Roy Jaggon Head of Performance Management</td>
</tr>
<tr>
<td>Approved by:</td>
<td>Gus Heafield</td>
</tr>
<tr>
<td>Presented by:</td>
<td>Roy Jaggon</td>
</tr>
</tbody>
</table>

**Purpose of the report:**

> To present to the Board the monthly service quality indicator report.

**Action required:**

> To review, the service quality indicator report, and note the planned way forward in development over the coming months.

**Recommendations to the Board:**

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

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

> The report provides quality indicator data for each CAG, and therefore provides a source of assurance of service quality.

**Summary of Financial and Legal Implications:**

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

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

> There are no immediate or direct implications to equality & diversity or public and patient involvement.
SERVICE QUALITY INDICATOR REPORT

This is a monthly report consisting of Monitor targets and internal indicators which are by CAG and by borough and provides a year to date view of performance.

This is a M2 report for the new financial year and is a continuation of the progress made over the last six months.

Month 2 Commentary

Patient Experience
This segment of the quality strategy illustrates a consistent picture for patient surveys and copies of care plans. CPA 12m review shows a marked improvement on last month and trajectories indicate that we will meet this indicator at the end of the quarter. The numbers of complaints are the total for the year so far, compared to the same period last year. Early indications are that the numbers of complaints are significantly less than last year.

Access
The Trust remains compliant with delayed discharges, and early intervention.

HTT gate keeping: Following the Quality Account Audit May 2013 the recommendation for this indicator is ‘Ensure that the exemptions being applied to the indicator are either agreed with Monitor/DH or ceased’. The Trust will comply with this recommendation by adhering strictly to the Monitor definition of exemptions for this indicator. This will include operational / data recording issues as well as changes to ePJS and therefore this is a period of transition. We are currently working on implementing these changes and reporting using the Monitor definition for the Q1 Monitor submission.

Patient safety
Overall the Trust meet the 7 day f/u target which is applicable to all adults services (AMH, MHOA and specialist services). We review performance of CAMHS against this target as it is considered an area of good practise. CAMHS have relatively small numbers and there were two patients not followed up last month. These two cases are currently being investigated and we will review at CEO PMR. We remain consistent at 92.169% for Child need risk screen however for the Psych Med figures have dropped by 3% and this is currently under review. Detailed feedback will be available at the meeting.

Following discussion at the last meeting incidents data and RIDDOR data is now based on a rolling 12 months compared to last year. This provides a more robust perspective of data over a longer period and suggests that for incidents, the year on year is comparable. However when looking at individual CAGs it is noticeable that BDP and Psychosis CAGs would seem to have more incidents than last year. This is being investigated and a verbal update will be available at the meeting.

Patient Outcomes and Safeguarding
The Trust continues to deliver on paired outcome scores across all CAGs.

Inpatient and Community Contextual Information
This information is similar to previous months and shows no significant variations in activity.
Roy Jaggon
Head of Performance Management
Strategy and Business Development Directorate
1. Surveillance report of Blood borne viruses, alert organisms and outbreaks

<table>
<thead>
<tr>
<th>Condition</th>
<th>Details</th>
</tr>
</thead>
<tbody>
<tr>
<td>MRSA</td>
<td>Nil cases</td>
</tr>
<tr>
<td>CMRSA, PVL* etc</td>
<td>Nil cases</td>
</tr>
<tr>
<td>Antibiotic resistant infections, e.g. ESBL, VRE**</td>
<td>Nil cases</td>
</tr>
<tr>
<td><em>E. coli</em> bacteremia</td>
<td>Nil cases</td>
</tr>
<tr>
<td>C. difficile</td>
<td>Nil cases</td>
</tr>
<tr>
<td>Pulmonary tuberculosis</td>
<td>A patient who had attended a Community Mental Health Unit was found to have Pulmonary TB. The ICT liaised with the Consultant in Communicable Disease Control at the local Public Health England Unit in Croydon for the follow-up of patient and staff contacts.</td>
</tr>
<tr>
<td>Hepatitis C</td>
<td>For the month of May 2013, 2 of the 34 patients screened for Hepatitis C antibody were positive.</td>
</tr>
<tr>
<td>Hepatitis B</td>
<td>For the month of May 2013, 35 patients were tested for HepBsAg. Following further tests, none were found to be HepBeAg positive.</td>
</tr>
<tr>
<td>HIV</td>
<td>For the month of May 2013, 25 Inpatients and 2 Community were tested for HIV. All results were negative.</td>
</tr>
</tbody>
</table>
| Diarrhoea and vomiting Outbreaks:             | **Children & Adolescent Mental Health Inpatient Unit, Kent [20 beds] – Commenced 23 May 2013 2 patients were affected. Unit closed 24 – 26 May 2013**  
**Mother & Baby Unit, Bethlem site [12 beds] – Commenced 27 May 2013 6 Patients were affected. Unit closed 28 May- 5 June 2013 Six samples tested positive for Norovirus species**  
**Psychiatric Inpatient ward, Ladywell Unit [18 beds] – Commenced 31 May 2013 5 patients were affected. Unit closed 31 May - 4 June 2013** Following investigations, food was not implicated and the pattern suggests that the outbreaks were of viral origin. |

* Panton Valentine Leucocidin  
** Extended spectrum beta-lactamases; Vancomycin Resistant Enterococcus
May 2013 - Month 2

**PATIENT EXPERIENCE & ACCESS INDICATORS**

### Patient Experience Indicators

<table>
<thead>
<tr>
<th>CAGs</th>
<th>PEDIC Survey in Progress Year To Date - 2013/14</th>
<th>CarePlan Copy Given Year To Date - 2013/14</th>
<th>CPA - 12 Month Review As at 17th June 2013 May M02 - 2013/14 Quarterly Target</th>
<th>Complaints M2 - May 2013 YTD</th>
</tr>
</thead>
<tbody>
<tr>
<td>Addictions</td>
<td>100.00%</td>
<td>N/A</td>
<td>94.91%</td>
<td>-0.29%</td>
</tr>
<tr>
<td>Behavioural and Developmental Psychiatry</td>
<td>100.00%</td>
<td>5.00%</td>
<td>93.17%</td>
<td>-1.83%</td>
</tr>
<tr>
<td>Child and Adolescent Mental Health Services</td>
<td>100.00%</td>
<td>5.00%</td>
<td>97.39%</td>
<td>+2.39%</td>
</tr>
<tr>
<td>MHOA and Dementia</td>
<td>100.00%</td>
<td>5.00%</td>
<td>91.63%</td>
<td>-3.37%</td>
</tr>
<tr>
<td>Mood Anxiety and Personality</td>
<td>100.00%</td>
<td>5.00%</td>
<td>94.97%</td>
<td>-0.30%</td>
</tr>
<tr>
<td>Psychological Medicine</td>
<td>100.00%</td>
<td>5.00%</td>
<td>94.20%</td>
<td>-0.30%</td>
</tr>
<tr>
<td>Psychosis</td>
<td>100.00%</td>
<td>5.00%</td>
<td>94.12%</td>
<td>-0.88%</td>
</tr>
<tr>
<td>Totals</td>
<td>100.00%</td>
<td>5.00%</td>
<td>93.67%</td>
<td>-1.33%</td>
</tr>
</tbody>
</table>

*Please Note: the Do You Feel Safe? Questionnaire is due to be reported quarterly for 2013/14 under Patient Experience Indicators*

### Access Indicators

<table>
<thead>
<tr>
<th>CAGs</th>
<th>Delayed Discharges Year To Date - 2013/14</th>
<th>HTT Gatkeeping Year To Date - 2013/14</th>
<th>Early Intervention: New Referrals As at 31st May 2013</th>
</tr>
</thead>
<tbody>
<tr>
<td>Addictions</td>
<td>Days Lost</td>
<td>OBDS</td>
<td>%</td>
</tr>
<tr>
<td>Behavioural and Developmental Psychiatry</td>
<td>0</td>
<td>507</td>
<td>0.00%</td>
</tr>
<tr>
<td>Child and Adolescent Mental Health Services</td>
<td>0</td>
<td>7,019</td>
<td>0.00%</td>
</tr>
<tr>
<td>MHOA and Dementia</td>
<td>19</td>
<td>3,409</td>
<td>0.56%</td>
</tr>
<tr>
<td>Mood Anxiety and Personality</td>
<td>0</td>
<td>3,457</td>
<td>0.00%</td>
</tr>
<tr>
<td>Psychological Medicine</td>
<td>0</td>
<td>1,208</td>
<td>0.00%</td>
</tr>
<tr>
<td>Psychosis</td>
<td>0</td>
<td>4,788</td>
<td>0.00%</td>
</tr>
<tr>
<td>Totals</td>
<td>1,884</td>
<td>23,901</td>
<td>7.06%</td>
</tr>
</tbody>
</table>

| Days Lost | OBDS | % | 7.59% | % | 95.00% | % | 100.00% |
| 1,884 | 23,901 | 7.06% | +0.19% | N/A | 100.00% | 0.00% |

| Days Lost | OBDS | % | 7.59% | % | 95.00% | % | 100.00% |
| 1,884 | 23,901 | 7.06% | +0.19% | N/A | 100.00% | 0.00% |
May 2013 - Month 2

PATIENT SAFETY INDICATORS

<table>
<thead>
<tr>
<th>Patient Safety Indicators</th>
<th>CPA 7 Day Follow-Up %</th>
<th>CPA 7 Day Follow-Up Numbers</th>
<th>Brief/Full Risk Screen</th>
<th>Child Risk Screen</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>%</td>
<td>+</td>
<td>%</td>
<td>+</td>
</tr>
<tr>
<td>Addictions</td>
<td>N/A</td>
<td>N/A</td>
<td>98.22%</td>
<td>+ 18.22%</td>
</tr>
<tr>
<td>Behavioural and Developmental Psychiatry</td>
<td>100.00%</td>
<td>+ 5.00%</td>
<td>98.22%</td>
<td>+ 18.22%</td>
</tr>
<tr>
<td>Child and Adolescent Mental Health Services</td>
<td>83.33%</td>
<td>- 11.67%</td>
<td>96.00%</td>
<td>0.00%</td>
</tr>
<tr>
<td>MHOA and Dementia</td>
<td>100.00%</td>
<td>+ 5.00%</td>
<td>96.00%</td>
<td>0.00%</td>
</tr>
<tr>
<td>Mood Anxiety and Personality</td>
<td>100.00%</td>
<td>+ 5.00%</td>
<td>96.00%</td>
<td>0.00%</td>
</tr>
<tr>
<td>Psychological Medicine</td>
<td>100.00%</td>
<td>+ 5.00%</td>
<td>96.00%</td>
<td>0.00%</td>
</tr>
<tr>
<td>Psychosis</td>
<td>98.26%</td>
<td>+ 3.35%</td>
<td>96.00%</td>
<td>0.00%</td>
</tr>
<tr>
<td>Totals</td>
<td>98.35%</td>
<td>+ 3.35%</td>
<td>98.35%</td>
<td>+ 3.35%</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>CPA 7 Day Follow-Up %</th>
<th>CPA 7 Day Follow-Up Numbers</th>
<th>Brief/Full Risk Screen</th>
<th>Child Risk Screen</th>
</tr>
</thead>
<tbody>
<tr>
<td>%</td>
<td>+</td>
<td>%</td>
<td>+</td>
</tr>
<tr>
<td>Croydon</td>
<td>98.65%</td>
<td>+ 3.65%</td>
<td>93.93%</td>
</tr>
<tr>
<td>Lambeth</td>
<td>97.37%</td>
<td>+ 2.37%</td>
<td>96.01%</td>
</tr>
<tr>
<td>Lewisham</td>
<td>98.57%</td>
<td>+ 3.57%</td>
<td>96.33%</td>
</tr>
<tr>
<td>Southwark</td>
<td>98.44%</td>
<td>+ 3.44%</td>
<td>94.08%</td>
</tr>
<tr>
<td>Totals</td>
<td>98.35%</td>
<td>+ 3.35%</td>
<td>98.35%</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Violence and Aggression</th>
<th>Patient Falls</th>
</tr>
</thead>
<tbody>
<tr>
<td>Violent St's</td>
<td>June 11 to May 13</td>
</tr>
<tr>
<td>17</td>
<td>10</td>
</tr>
<tr>
<td>252</td>
<td>293</td>
</tr>
<tr>
<td>88</td>
<td>64</td>
</tr>
<tr>
<td>56</td>
<td>32</td>
</tr>
<tr>
<td>14</td>
<td>16</td>
</tr>
<tr>
<td>25</td>
<td>56</td>
</tr>
<tr>
<td>298</td>
<td>281</td>
</tr>
<tr>
<td>750</td>
<td>752</td>
</tr>
</tbody>
</table>

The above table shows the figures for Violence & Aggression. There is a RAG rating used, based upon the comparison between two periods of 12 month rolling average - May 2013 to June 2012 vs May 2012 to June 2011 (last year). For Patient Falls the comparison is based on May 13 vs May 12 (last year). The figures are representative of cases / incidents recorded on Datix.

Green highlights where there is a reduction in the figure when compared to last year.

Amber highlights where the figure is the same and not greater than 5 when compared to last year.

Red highlights where the figure is greater than 5 when compared to last year.

Please Note: the CRB Checks reporting is due to start in Q1 - 2013/14.
## May 2013 - Month 2

### Patient Outcomes & Safeguarding

<table>
<thead>
<tr>
<th>CAGs</th>
<th>Paired Outcome Score</th>
</tr>
</thead>
<tbody>
<tr>
<td>Addictions - 3 Month Rolling as at 31st May 2013</td>
<td></td>
</tr>
<tr>
<td>Behavioural and Developmental Psychiatry</td>
<td></td>
</tr>
<tr>
<td>Child and Adolescent Mental Health Services - YTD</td>
<td></td>
</tr>
<tr>
<td>MHOA and Dementia - YTD</td>
<td></td>
</tr>
<tr>
<td>Mood Anxiety and Personality - YTD</td>
<td></td>
</tr>
<tr>
<td>Psychological Medicine - YTD</td>
<td></td>
</tr>
<tr>
<td>Psychosis - YTD</td>
<td></td>
</tr>
<tr>
<td>TOPS Compliance Report</td>
<td></td>
</tr>
<tr>
<td>Start</td>
<td>98.28%</td>
</tr>
<tr>
<td>Exit</td>
<td>95.92%</td>
</tr>
<tr>
<td>CGAS Reporting</td>
<td>94.10%</td>
</tr>
<tr>
<td>HONOS Reporting</td>
<td></td>
</tr>
<tr>
<td></td>
<td>100.00%</td>
</tr>
</tbody>
</table>

Please Note: the Safeguarding reporting is due to start in Q1 - 2013/14
# May 2013 - Month 2 (YTD)

**Inpatient Contextual Information**

<table>
<thead>
<tr>
<th>CAGa</th>
<th>No of Beds - as per Bed State Report</th>
<th>LOS (Days) - 12 month rolling average figure</th>
<th>Admissions (YTD)</th>
<th>Transfers In (YTD)</th>
<th>Transfers Out (YTD)</th>
<th>Discharges (YTD)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Addictions</td>
<td>12</td>
<td>8</td>
<td>88</td>
<td>0</td>
<td>0</td>
<td>65</td>
</tr>
<tr>
<td>Behavioural and Developmental Psychiatry</td>
<td>105</td>
<td>264</td>
<td>11</td>
<td>106</td>
<td>97</td>
<td>15</td>
</tr>
<tr>
<td>LD</td>
<td>30</td>
<td>95</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Child and Adolescent Mental Health Services</td>
<td>63</td>
<td>67</td>
<td>40</td>
<td>2</td>
<td>1</td>
<td>39</td>
</tr>
<tr>
<td>MHOA and Dementia</td>
<td>186</td>
<td>71</td>
<td>55</td>
<td>6</td>
<td>6</td>
<td>51</td>
</tr>
<tr>
<td>Mood Anxiety and Personality</td>
<td>27</td>
<td>133</td>
<td>10</td>
<td>1</td>
<td>3</td>
<td>18</td>
</tr>
<tr>
<td>Psychological Medicine</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Triage</td>
<td>44</td>
<td>5</td>
<td>414</td>
<td>20</td>
<td>205</td>
<td>232</td>
</tr>
<tr>
<td>Other</td>
<td>48</td>
<td>87</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Psychosis</td>
<td>235</td>
<td>31</td>
<td>245</td>
<td>337</td>
<td>158</td>
<td>426</td>
</tr>
<tr>
<td>Other</td>
<td>130</td>
<td>290</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Totals</td>
<td>880</td>
<td>1,065</td>
<td>843</td>
<td>472</td>
<td>471</td>
<td>846</td>
</tr>
</tbody>
</table>

**Please Note:** the No of Beds has been populated via Bed State Live - with the figures taken on 12Th June 2013 - refresh time was 09.38am.

**Please Note:** due to ward closures within Behavioural & Developmental Psychiatry and opening of the new EFFRA ward within River House the higher numbers of Transfers In & Out will represent these changes.
## May 2013 - Month 2

### Community Contextual Information

#### CAGs

<table>
<thead>
<tr>
<th>Category</th>
<th>Caseload M02 - May 2013</th>
<th>Discharges (YTD)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Addictions</td>
<td>3,551</td>
<td>394</td>
</tr>
<tr>
<td>Behavioural and Developmental Psychiatry</td>
<td>3,021</td>
<td>428</td>
</tr>
<tr>
<td>Child and Adolescent Mental Health Services</td>
<td>6,172</td>
<td>897</td>
</tr>
<tr>
<td>MHOA and Dementia</td>
<td>4,648</td>
<td>754</td>
</tr>
<tr>
<td>Mood Anxiety and Personality</td>
<td>5,667</td>
<td>809</td>
</tr>
<tr>
<td>Psychological Medicine</td>
<td>4,947</td>
<td>1,559</td>
</tr>
<tr>
<td>Psychosis</td>
<td>7,916</td>
<td>272</td>
</tr>
<tr>
<td>Totals</td>
<td>35,922</td>
<td>5,113</td>
</tr>
</tbody>
</table>

#### Community

<table>
<thead>
<tr>
<th>12 month rolling</th>
<th>Patient Seen</th>
<th>Appointment attended</th>
<th>Group Contacts</th>
<th>Phone Calls</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total</td>
<td>5,374</td>
<td>60,239</td>
<td>4,462</td>
<td>23,209</td>
</tr>
<tr>
<td>Croydon</td>
<td>2,162</td>
<td>11,114</td>
<td>1,402</td>
<td>9,988</td>
</tr>
<tr>
<td>Lambeth</td>
<td>7,776</td>
<td>54,730</td>
<td>4,861</td>
<td>49,946</td>
</tr>
<tr>
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<td>69,088</td>
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#### Boroughs

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<td>Southwark</td>
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<td>Total</td>
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<th>Patient Seen</th>
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Date of Board meeting: 25th June 2013

Name of Report: SLAM Clinical Audit Annual Report 2012/13

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

Author: Rosie Peregrine-Jones
Assistant Director of Quality and Assurance

Approved by: Jane Sayer, Acting Director of Nursing and Education
(name of Exec Member)

Presented by: Jane Sayer/Rosie Peregrine-Jones

Purpose of the report:
To inform the Trust Board of the corporate clinical audit work undertaken in 2012/13 and priorities for 2013/14.

Action required:
The Trust Board is asked to comment on the content and suggest further objectives/priorities for inclusion in 2013/14 program.

Recommendations to the Board:
As above

Relationship with the Assurance Framework (Risks, Controls and Assurance):
The Trustwide Clinical Audit program provides assurance for the following risk in the Assurance Framework: ‘The Trust is unable to demonstrate the clinical quality of its services explicitly’. Audits also provide assurance that other clinical risks in the Assurance Framework (e.g. substance misuse, violence, supervised confinement, MHA compliance, etc. have controls in place etc.

Summary of Financial and Legal Implications:
The Trustwide Clinical Audit Program provides assurance that clinical policies are being implemented and improvements are being made and was critical in the Trust successfully achieving NHSLA level 3 in the assessment in December 2011. Clinical audit programs are key source of assurance for CQC visits and are required to be declared in the SLAM Quality Account. Audit work also has a place in monitoring CQUINs and Quality Contract targets with sanctions.

Equality & Diversity and Public & Patient Involvement Implications:
The organisation must ensure that the process for determining choice of clinical audit projects and the manner in which they are drawn up does not inadvertently discriminate against any groups in society based on their race, disability, gender, age sexual orientation, religion and belief. Equality data is collected as part of clinical audits in order to determine whether any particular groups of patients are experiencing variations in access or clinical practice.
SLaM Clinical Audit Annual Report
2012/13

6th June 2013

Clinical Audit & Effectiveness Team
111 Denmark Hill
Maudsley Hospital
Camberwell
SE5 8AZ
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<tr>
<td>actions taken as a result of audit and dissemination of findings, and</td>
<td></td>
</tr>
<tr>
<td>recommendations</td>
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<td>12</td>
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1. Executive Summary
Key achievements of the SLaM corporate audit program and related activity over the
past year have included: the delivery of the prioritised annual audit plan – 31
projects were completed by end of March 13 and a further 7 projects were underway
and carried over to 2013/14 program. This is an increase in the number of completed
projects compared with previous years (17 completed in 2010/11 and 28 in 2011/12).
A significant number of projects 14/31 (45%) were monitoring CQUIN/Quality
Contract standards. The increase in CQUIN contracted audits has had an impact on
the capacity of the team to cover the usual range of reviews of SLAM clinical policy
areas. Compared with 2011/12 program, the number of policy re-audits has fallen by
50% from 13 to 7 in the past 12 months (2012/13).

In terms of impact of the trustwide audit program: re-audits demonstrate
improvements in some clinical policy areas particularly supervised confinement,
AWOL and Section 58 and Section 132 rights giving. Less progress has been made
on rapid tranquilisation mandatory monitoring and safeguarding adults however,
action plans have been put in place to address the issues. Other improvements that
have occurred following audit include: modification of Events tab in EPJs to make it
easier for clinicians to record patient information discussions and for auditors to
monitor informed consent and patient information delivery; the setting up of
supervised confinement action planning team and bimonthly meetings to address
practice issues identified by the audit; provision of funding for full-time Trustwide
Safeguarding Adults Lead post; review of diabetes training and education for staff
and negotiation of CQUIN in 2013/14 to provide further incentives to improve practice
in this area. In terms of the CQUINs that the team supported in 2012/13, the targets
were met on the annual physical health checks for long-stay patients, and smoking
cessation but were not met in the areas of GP input into discharge plans and targets
for two self-defined recovery goals in care plans. The CQUINs in the latter two areas
in 2013/14 have been revised in light of monitoring issues highlighted in the audit
reports.

The team has had success in dissemination of audit results winning awards at the
Kings Health Partners Safety Connections Conference in October 2012, the HQIP
national conference in April 2013 and the pan-London quality improvement network
(June 13). The DNAR project was also selected for poster display and presentation
at the International Healthcare forum held in Excel, London in April 2013.

In light of the Francis report, some key priorities for the Clinical Audit & Effectiveness
Team (CAET) in 2013/14 include a review of team’s aims and objectives including
CAET team mission statement, prioritisation process to ensure projects taken on are
action-focused, cost-effective and relevant to patients' and The Trust Board’s quality
concerns. Review to consider whether CQC fundamental standards and themes
from SLAM complaints, incidents and claims should be given priority over audits of
enhanced quality standards (e.g. NICE and NHSLA standards) and other requests
for service evaluation activity. CAET team review to also consider whether a
statement of assurance (limited, partial, significant, full assurance) should be given
on clinical policy areas following publication of audit findings. We plan to build on our
existing user involvement work and increase our collaboration with service users and
the CAET team. In 2013/14, service users will support the team with review of project
priorities, advise at project planning meetings with policy leads and assist with
interviewing patients. We also plan to increase our use of complaints data in
evaluating areas of clinical policy.
In addition to the above, we plan to review the Quality Governance Committee (QGC) terms of reference and function to ensure fundamental (CQC) standards of care are reviewed for compliance and action planned and user representation at committee is strengthened. Consultation on setting up a QGC/clinical audit Patient Advisory panel to aid prioritisation of quality areas for review, monitor and drive improvements will be included.

Other CAET objectives for 2013/14 include:

- Re-establish a quarterly Quality Governance and Audit SLAM network meeting
- CAET to provide supervision and support to QI project underway to improve the support offered to junior doctors undertaking an audit to ensure more reports are completed and trainee doctors contributions are recognised and rewarded.
- Completion of the Trustwide programme of audits to assist with CQC assurances, CCG Quality Contract & CQUIN requirements, NHSLA policy and NICE quality standards.
- Continue our collaboration with Kings Health Partners Clinical Governance Teams to hold a Patient Safety Conference and Awards in 2014.
- Provide continued support to CAET ‘Mind the Gap’ community project which aims to challenge stigma associated with mental health and also provide information for the public on how to get help.
2. Corporate Clinical Audit Program Activity (2012/13)

2.1 Participation in National Audits:
During 2012/13, five national clinical audits covered NHS services that the South London and Maudsley NHS Foundation Trust provides. During that period SLaM participated in 100% national clinical audits which it was eligible to participate in.

The national clinical audits that the SLaM was eligible to participate in during 2012/13 are listed below:
- The national audit of psychological therapies for anxiety and depression with 6 teams taking part
- The four national, Prescribing Observatory for Mental Health - POMH-UK audits:
  - Prescribing of anti-dementia drugs & prescribing antipsychotic medication for people with dementia
  - Assessment of the side effects of anti-psychotics
  - High dose/polypharmacy antipsychotic prescribing
  - Prescribing in personality disorder

Participation in the Prescribing Observatory (POMH-UK) managed by the Royal College of Psychiatrist’s Centre for Quality Improvement

<table>
<thead>
<tr>
<th>TOPIC</th>
<th>Participation by trust</th>
<th>National participation</th>
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</thead>
<tbody>
<tr>
<td></td>
<td>Number of teams</td>
<td>Number of patients</td>
</tr>
<tr>
<td>Prescribing high-dose and combination antipsychotics: acute/PICU, rehabilitation/complex needs, and forensic psychiatric services</td>
<td>43</td>
<td>434</td>
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<tr>
<td>Prescribing for people with a personality disorder</td>
<td>49</td>
<td>91</td>
</tr>
<tr>
<td>Screening for metabolic side effects of antipsychotic drugs</td>
<td>21</td>
<td>228</td>
</tr>
<tr>
<td>Prescribing antipsychotic medication for people with dementia</td>
<td>23</td>
<td>434</td>
</tr>
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</table>

The Royal College of Psychiatrists National Audit on Schizophrenia fed-back Trust level results to SLAM in June 2012 and the results were discussed and action planned at the Psychosis CAG Care Pathways Executive. The action plan was updated again early 2013 to consider the findings and recommendations from the national audit report published in December 2012. The summary feedback in the Trust level report demonstrated that SLaM performed in the middle range on most of the key standards. In common with other trusts, SLAM scores on the physical health indicators was the weakest area of performance (i.e. under 50% compliance). Physical health is therefore a huge priority for SLaM and much work is underway to ensure better physical health in our service users. A broad approach is taken to this, incorporating access to routine population screening, lifestyle interventions, appropriate long-term condition management where indicated and access to acute medical care. A CQUIN target in 13/14 has also been negotiated with the CCGs as a further incentive to improve performance in this area.

About two thirds of people with psychosis smoke, a much higher proportion than in the general population. A smoking policy has been introduced in SLaM to address this and a conference was held on May 9th 2013 in collaboration with local Primary care, public health and respiratory physicians to agree the best ways to reduce smoking rates in people with psychosis. Smoking cessation has also been agreed at one of the 9 SLAM quality priorities in 13/14.
2.2 SLaM Corporate Audit Programme 2012/13:
The SLaM Corporate Clinical Audit Programme in 2012/13 was split between three areas to reflect the dimensions of quality highlighted in ‘High Care Quality for All’. In 2012/13, 31 projects were completed by end of March 13 and a further 7 projects were underway and carried over to 13/14 program. A significant number of projects 14/31 (45%) were monitoring CQUIN/Quality Contract standards. Five projects were de-commissioned following advice from policy leads including: physical health (MEWS) audits- deferred following advice that work was being carried out in other areas of the Trust that the audit would duplicate; the policy lead agreed that the Health Records Audit could be conducted by the Health Records Department, the Dual Diagnosis Audit felt to be partially covered by inclusion of relevant questions in the Patient Information Audit and the NICE Psychosis and Substance Misuse Audit; Falls and National Confidential Enquiry audits were covered by other audits (suicides prevention, MHOA falls risk audit). A Discharge and Transfer policy audit was also decommissioned as a quarterly CQUIN audit had been agreed on this topic ‘GP involvement in CPA discharge planning’.

- Patient Safety: This was a programme of audit and re-audit of NHSLA clinical policies. Completed projects include audits of: Observation and Engagement, Safeguarding Adults, Care and Support of Pregnant Women with Serious Mental Illness, and AWOL.

- Clinical Effectiveness: This included audits of the NICE Violence Guideline (Supervised Confinement, Physical Intervention and Rapid Tranquilisation), NICE Guideline for Self Harm Longer Term Management, and Diabetes Audit

- Patient Focus: Completed audits include Section 58/Section 132, Ethnicity and Spirituality Care Plans Audit and Re-Opened complaints audit.

- PCT/CQUIN’s: This included quarterly reports on self-defined recovery goals in care plans, annual physical health checks, discharge plans and GP input into plans. Other CQUIn’s included Croydon Social Inclusion Audit and Smoking Cessation Audit.

- Other Projects: The SLAM Clinical Audit Team also provided support to other clinical quality improvement projects including data analysis of the Nursing Practice Visit data, the Magnet Nursing Engagement Staff Survey, Productive Wards Team Leader Evaluation, Audit of PSTS Training on Inpatient Wards and the Consultants Appraisal Audit.

3. Impact of the SLaM corporate audit program including re-audits, actions taken as a result of audit and dissemination of findings, and recommendations.

3.1 Re-audits
The SLaM Corporate Audit Program is now in its fifth re-audit cycle. Demonstrable improvements have been shown across criteria in 2012/13. These include:

i) Supervised Confinement: Since the first audit in 2009, there have been clear improvements in the areas of completed risk assessment documentation prior to the incident, reviewing informal patients for MHA status soon after supervised confinement commences, ensuring 100% of supervised confinement forms are signed by person initiating confinement, ensuring
observations/physical checks at reviews, improvements to timeliness of reviews and records of food and fluid intake.

ii) AWOL: Occurrences of AWOL/missing persons and/or reporting rates have reduced whilst routes of reporting within the Trust have shifted: reported AWOLs dropped from 103 in the month of September 2010 to an average 51.3 per month in April-June 2012. In 2012 audit, the speed with which patients return has also improved 47/73, 64.4% returned within 6 hours compared to 47/114, 41.2% in 2010. The proportion of AWOLS reported correctly via both DATIX and MHA Office routes increased a little, from 56/103 (54.4%) in 2010 to 92/154 (59.7%) in 2012. In all cases reported to the MHA Office an AWOL 2 form had been completed (100%).

iii) Section 58 Consent to Treatment Audit: All of the service users detained for over 3 months had a current authorising form on either ePJS or attached to their drug chart. Six of these (11.8%) only had emergency S62 forms. This is a large improvement on 2009 when 11/47 (23.4%) service users were on S62 and 11/47 (23.4%) did not have any authorising form. All (100%) the current T2s and T3s had the necessary details completed (including signature and date). This has gone up slightly since the 2009 audit (86%). 47/51 (92.2%) service users had been given S132 rights and all these documented using the correct form. This is an improvement on the 2009 finding (74%).

iv) Physical Intervention (PI) - For those who were considered to be at risk of violence 37/50 (74%) had specific interventions for short term management of challenging or violent behaviour mentioned in their care plans/case formulation compared to 52% in 2011 audit. Documentation of de-escalation attempts has improved - Attempts to de-escalate the situation prior to restraint were made in 42/56 (75%) of cases compared to 65% in 2011. Improvements in updating care plans and risk documentation following PI were observed and a reduction in the proportion of patients being placed in supervised confinement or a more secure area following restraint.

v) Observation/Engagement audit: there was a visual handover at the beginning of every shift for all wards visited 28/28 (100%). The handover accounted for all of the patients present on the ward and all other patients, including their whereabouts (28/28, 100%). All wards visited during the day 28/28 (100%) and at night 14/14 (100%) completed general observations as a minimum requirement hourly. In all cases of within arms length observations that were observed by the auditor 2/2 (100%) included positive engagement with the service user. Service users remained within eyesight of the staff in 14/16 (88%) of the cases Unpredictable intermittent observations took place in 21/27 (89%) of cases

Two re-audit projects showed areas of policy where performance has declined/remained unchanged since last cycle of audit. Actions to address these policy areas have been highlighted in Section 3.2 below:

i) Rapid Tranquillisation Physical Observations (November 12)– performance remains unchanged i.e. poor compliance with mandatory monitoring requirements at frequency required in policy. There were no cases of physical observations being taken every 5-10 minutes for at least an hour

ii) Safeguarding Adults – performance has declined since 2010 audit on majority of criteria.
3.2 Actions taken as a result of audit findings

In reviewing the impact of the audit program, a number of actions have been taken following the audit to secure improvements in the quality of health care provided, including:

- **Supervised Confinement (SC):** new policy ratified in 2012 and a SC working party established; half-day SC awareness/action planning event, chaired by medical director, was held on 30th November 2012; service user rights in SC laminated sheet sent to wards with SC rooms to encourage display/discussion with patients; new SC registers in place on wards with SC rooms. Bimonthly action planning meeting held by Interim Deputy Director of Nursing, Peter Hasler throughout 2013 and re-audit planned for Q3 2013/14.

- **Safeguarding adults** – funding has been ring-fenced for new full-time Trustwide Safeguarding Adults Lead post in 2013/14 (6 month secondment).

- **Enhanced Observation** - A sub group of the practice council ‘Nursing at Night’ is developing an agreed set of actions. The Observation and Engagement policy will be updated to include more detailed expectations of night time observations in Spring 2013. The Enhanced Observation/Engagement Record was updated in August 2012 to include more space to record and initiation date and time. Audit findings were circulated to all inpatient areas with recommendations to teams.

- **Patient Information** – Since the last audit in October 2011, a quarterly patient information bulletin has been circulated to teams which includes names of newly published patient information leaflets, details on how to order leaflets and information on standards of information giving. An information recording facility in ‘Events’ Tab of EPJs appears in the 18 May 4.33 EPJS release. This will make it easier for staff to record discussions and information sharing. A laminated poster which highlights what information patients are entitled to receive has been distributed to wards to display.

- **Care and Support of Pregnant Women with SMI** – audit findings discussed at Perinatal Executive 08/08/2012. Perinatal care plan template to be used for all complex cases, i.e. all that come onto the nurse caseloads. Erroneous use of ‘CPA’ acknowledged – staff encouraged to use ‘Perinatal Planning Meeting’ or ‘Perinatal Birth Plan Meeting’. Revised standards disseminated by Pamela Prescott, August 2012 and January 2013. Re-audit Q2 2013/14.

- **NICE Diabetes audit** – following presentation of Trustwide audit results which at Trustwide Physical Health Committee in January 2013, there is a plan to improve staff education within SLaM on recognition and treatment of diabetes including review and promotion of the Kings staff education package, patient health promotion activities and review of patient information on diabetes risks. A CQUIN has also been negotiated with CCGs for 13/14 to provide incentives for improvement in this area of care.

- **Rapid Tranquilisation (RT)** – pilot to improve mandatory physical health checks following RT on triage wards and PICUs introduced January 2013. Draft guidance procedure sheet and checklist for staff carrying out mandatory monitoring required to be attached to MEWs charts. Quarterly audit spot checks introduced to evaluate pilot.

3.3 Impact of CQUIN audits

The SLaM Corporate Audit Team has also been responsible for providing quarterly audit reports on a number of CQUIN and Quality Contract targets. Q4 compliance targets were met in the areas of physical health checks and smoking cessation documentation but less progress made in the areas of GP involvement in discharge
planning and recovery goal documentation. Factors contributing to achievement of annual physical health checks included the ‘rapid cycle’ audit methodology which involved the Audit Project Officer contacting consultants whose patients were due an annual health check to ensure these were done and recorded correctly by the end of the quarter. Factors contributing to the poorer performance against latter two CQUIN targets included delays in EPJs upgrade and launch of electronic Support and Recovery Care plan documentation and difficulties in method of CQUIN formulation (GP involvement in discharge plans).

- Annual physical health checks for patients with LOS > 1 year **TARGET MET**
  - Q1 100%. Q4 95.5%  Q4 Target = 95%  (0.5%) Sanction (1 million pounds)

- Smoking Cessation: smoking status recorded **TARGET MET**
  - Q4 smoking status recorded = 81%  Q4 Target =75%

- Smoking Cessation: patient involvement in care plan **TARGET MET**
  - Q4: 6.5%  Q4 Target = 2%

- Discharge Plans (contingency plans recorded and GP input into plan) **TARGET NOT MET**
  - Q1 30%  Q4 24%  Q4 Target = 90%

- Two or more Self Defined Recovery Goals in Care Plans: **TARGET NOT MET**
  - Q1 28.6% - Q4 37.1%. Q4 Target =50%

- Q3 Croydon Social Inclusion Audit - 40/50 (80%) cases had at least one assessment form prompting consideration of social inclusion needs. 31 social inclusion needs were identified and 22 (71%) of these had documentation that they were being addressed.

**3.4 Dissemination of audit findings and recommendations:**

**Internal within SLAM**

i) Presentation of corporate audit projects at CAG clinical governance/audit committees - Following presentation at the Quality Governance Committee (QGC), relevant corporate audit reports and recommendations are included as agenda items on CAG audit/clinical governance committees. CAG clinical governance committees are encouraged scrutinise their results and develop their own local action plans to improve performance.

Presentations have also been given of audit findings at various trustwide quality committees related to the audit/policy area. These have included the Physical Health Committee, MHA Committee, the Prevention of Violence and Aggression Committee, the Patient Information Strategy Group, the Equality and Human Rights Committee, Perinatal Exec and the Productives celebration event. This ensures that learning from the audits are taken forward by those directly involved and those leading policy and strategy in these areas.

ii) ‘Learning Lessons from Clinical Audit’ – one page project summaries
In order to spread ‘Trustwide the results and recommendations from audit, the CAET team have produce one page summaries of audit findings and key recommendations aimed at clinical staff. These have been distributed in the SLAM e-news bulletin and
been sent via e-mail Trustwide to team leaders and senior clinical staff. There are also links to the policy and education resources available.

**Kings Health Partners**

**iii) KHP Safety Connections Conference** – The patient safety conference was a collaboration between SLaM, Guys and St Thomas and Kings and took place over two days (11th and 12th October 2012). The conference was supported by a grant from the Maudsley Charity. The conference included speakers and workshops led by SLAM staff and a poster competition for projects relating to improvements in patient safety was also held. SLaM CAET team entered two audit projects – Observation and Engagement and Rapid Tranquilisation and one quality improvement project – ‘Closing the Gap’. The rapid tranquilisation audit won in the category Sustained Improvement.

**External Conferences and Awards**

**iv) On 26th September 2012 HQIP announced that they are provisionally awarding a contract to South London & Maudsley NHS Foundation Trust (SLAM) for the multi-site clinical audit: Audit of Modified Early Warning Score Implementation Across Mental Health Trusts and development of a Failure To Rescue indicator in MH.**

Starting in September 2012, over a three year period, this will involve training 18 mental health trusts around the country in the use of the MEWS and clinical audit tools to monitor its uptake and effectiveness.

**v) HQIP National Audit Awards – SLaM won two awards at the recent HQIP Conference held in London on 12th and 13th February 2013. The Rapid Tranquilisation audit won in the category Patient Safety and also won the Gold Award for achievement in more than one category (it was also short-listed under the Sustained Improvement category). A poster of Rapid Tranquilisation audit was also displayed for delegates to view during the conference and, following the award ceremony, the results were published on HQIP’s website.**

**vi) International HealthCare Forum– Four SLaM CAET projects were shortlisted for this international conference held in London (16-19th April 2013). SLaM’s rapid cycle audit of Do Not Attempt Resuscitate Decisions (DNAR) was selected for the poster display and a presentation of the findings was given during the conference.**

**vii) The DNAR poster also won a pan-London quality improvement network (HQIP) poster competition on 7th June 2013, held at St. Pancras Hospital. The judges commented that the poster was very high quality and they commended the use of rapid cycle audit and direct feedback to consultants as a quality improvement method.**

**3.5 Other objectives for the Clinical Audit & Effectiveness Team in 2012/13:**

- Review, implementation and monitoring of the new SLaM Clinical Audit Policy including a review of the Clinical Audit & Effectiveness Committee (CAEC) Committee terms of reference and function. Re-audit of clinical audit policy standards planned for Q4 2012/13. **ACHIEVED**

- Continue our collaboration with AHSC Clinical Governance Teams to hold a Patient Safety Conference and Awards in October 2012. **ACHIEVED**

- Review of the ‘Basic Clinical Audit’ training course delivered in line with HQIP curriculum standards. **ACHIEVED**
• Building our user involvement capacity within the CAET team and making greater use of complaints data and other patient feedback PARTLY ACHIEVED
• Developing secondary evidence that audit actions have been implemented (e.g. service user/mystery shopper’ spot checks) PARTLY ACHIEVED
• To continue to work with CAG Project Officers through facilitating a quarterly Clinical Governance and Audit network meeting NOT ACHIEVED

4. Service User Involvement in Clinical Audit
The CAET in 2012/13 facilitated service user involvement and service user perspective in audit and service evaluation through:
- Carrying out several projects involving service users in interviewing service users on wards to gain their unique perspective on policy standards i.e. ‘Culture, Spirituality and Care Plans Audit’, Observation and Engagement audit, Informal Patients Audit and Patient Information audit.
- Service user involvement in service improvements following audit: The success of our ‘Mind the Gap’ patient information project has led to a closer working relationship with service user consultants and the CAET.
- Following the success of the ‘Mind the Gap’ project a new Lambeth Inpatient Information trolley has been set up which is run by service users and some members of the CAET.

5. Audit Topic Priorities for SLaM Corporate Audit Programme in 2013/14
The selection of topics for the 13/14 audit programme has been influenced by the Francis report, requirement to participate in relevant national audits, re-audits of the NHSLA clinical policies, CQC annual reports (MHA and MCA) and quality contract/CQUIN monitoring requirements.

i) Risk/NHSLA:
Clinical Supervision, Patient Information, Suicide Prevention Audit, DNAR, Rapid Tranquilisation, Mortality Audit, Violence/Clinical Risk Assessment, Care and Support of Pregnant Women with SMI, Observation and Engagement, Physical Health/Deteriorating Patient, AWOL, Supervised Confinement, Physical Intervention, Dual Diagnosis, Impact of Safeguarding Adults and Children Training, Staff Support, Moving and Handling and Inoculation Incidents, Being Open.

ii) NICE:
Three Trustwide audits of NICE guidance have been prioritised in the corporate audit program in 2013/14: The Bipolar NICE Guideline Audit, re-Audit of Self Harm Longer Term Management NICE Guideline and the National Audit of Schizophrenia. Action planning in response to the national report on the audit of psychological treatments for anxiety and depression will also be provided by the Clinical Audit & Effectiveness Team. Audits/monitoring of other NICE guidelines have been delegated to CAGs to include in their audit priority list for 2012/13 financial year. Supervision and support for NICE related audits is offered by the Clinical Audit & Effectiveness Manager.
iii) Patient Focus:
Mental Capacity Act, Nutrition Essence of Care Ward Audit, Consent to Treatment and Leave for Informal Patients, Consent to Treatment (section 58) and Section 132 Rights Audit and Complaints Audit.

d) CQUINs/CCG quality contract audits in 13/14
Recovery:
i) Percentage of community adult mental health patients with recovery and support care plans to include an quality audit in Q3
ii) Two self-defined recovery goals in care plans (Q2 and Q4 audit)

Physical Health:
iii) Physical Health: Diabetes monitoring including admission checks and checks at 4 months for patients prescribed antipsychotic drugs.

Discharge plans:
iv) Discharge Plans and GP Input into Plans

Smoking Cessation:
v) Smoking Cessation: Percentage of service users involved in developing their smoking cessation care plan

v) National Audits that SLaM has registered for participation in 2013/14:
There is one national audit that mental health trusts are required to participate in 2013/14 and document in their quality accounts which is the national schizophrenia re-audit which will start in the summer 2013. SLaM will also be participating in the Prescribing in mental health services (POMH-UK) national pharmacy audit program.

6. Other objectives for the Clinical Audit & Effectiveness Team in 2013/14:
• **CAET Team review** to include: development of team mission statement, review of clinical audit project prioritisation process to ensure projects are action-focused, cost-effective and relevant to patients’ and The Trust Board’s quality concerns. Review to consider whether CQC fundamental standards and themes from SLAM complaints, incidents and claims should be covered prior to undertaking audits of enhanced quality standards (e.g. NICE and NHSLA standards) and service evaluations.
• **CAET team review to include consultation on whether a statement of assurance (limited, partial, significant, full assurance) should be given on clinical policy areas following publication of audit findings.**
• **Building our user involvement capacity** and increase our collaboration with service users and the CAET team. Service User involvement activity to include review of priorities, support on project planning meetings with policy leads, interviewing patients and increasing our use of complaints data in evaluating area of clinical policy.
• **Quality Governance Committee (QGC) terms of reference review** of function to ensure fundamental (CQC) standards of care are reviewed for compliance and action planned and user representation at committee is strengthened.
• **Consultation on setting up a QGC/clinical audit Patient Advisory panel** to aid prioritisation of quality areas for review, monitor and drive improvements. Patient Advisory panel to develop secondary evidence that audit actions have been implemented (e.g. service user/mystery shopper’ spot checks)
• Re-establish a quarterly Quality Governance and Audit SLAM network meeting
• CAET to provide supervision and support to QI project underway to improve the support offered to junior doctors undertaking an audit to ensure more reports are completed and trainee doctors contributions are recognised and rewarded.
• Completion of the Trustwide programme of audits to assist with CQC assurances, CCG Quality Contract & CQUIN requirements, NHSLA policy and NICE quality standards.
• Continue our collaboration with Kings Health Partners Clinical Governance Teams to hold a Patient Safety Conference and Awards in 2014.
• Provide continued support to CAET ‘Mind the Gap’ community project which aims to challenge stigma associated with mental health and also provide information for the public on how to get help.
TRUST BOARD OF DIRECTORS – SUMMARY REPORT

Date of Board meeting: 25th June 2013

Name of Report: Finance Report 2013/14 – May 2013

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

Authors: Nick Dawe and Tim Greenwood

Approved by: Nick Dawe

Presented by: Nick Dawe

Purpose of the report:

This paper is designed to report to the Board on the financial performance of the Trust. In addition the paper identifies issues of concern and actions to address these issues. At the end of May the financial performance of the Trust remains unsatisfactory with action being required to deliver a balanced year-end out-turn and to protect a financial risk rating of 3.

Action required:

The Board is requested to review the report, make comments on the performance to date and consider the recommendations set out below:

Recommendations to the Board:

The following key actions are recommended to the Board:

That the Psychosis over spend paper is considered and approval given to actions within it and a break-even trajectory from Month 3 – Month 12 is agreed and closely monitored.

That the BDP over spend paper is considered and approval given to actions within it and a break-even trajectory from Month 3 – Month 12 is agreed and closely monitored.

That an over spend analysis and action plan paper is requested from Estates for the July Board.

That all support is given to concluding contract discussions with the Specialist Commissioners at the end of June and to support representations to the NHS Commissioning Board if the suggested contract shows any more than a net 4% reduction in value from 2012/13 (i.e. the CIP reduction).

That at the July Board meeting if Croydon CCG fails to commission the additional Triage Ward (currently open at risk), that the Trust would reduce commissioned bed numbers to the level stipulated in the CCG contract and recover any over spend incurred over that later months of the year.

That every effort is made to protect the financial risk rating of 3 at quarter one by careful attention to income and expenditure phasing, the correct representation of provisions and the management of discretionary spend activity.
Relationship with the Assurance Framework (Risks, Controls and Assurance):

The report is a key component of the assurance framework in terms of the effective and efficient management of resources.

Summary of Financial and Legal Implications:

The Trust must make the best possible use of public money and meet regulatory requirements and deliver to plan.

Equality & Diversity and Public & Patient Involvement Implications:

No direct implications
1. **Headlines**

- £1.5m net deficit (£1.5m adverse variance from plan) – see Table 1
- £1.3m EBITDA (£1.9m adverse variance from plan) – an adverse variance of £433k in the month
- If this variance was to continue, a risk rating of 2 would be achieved in Q1 under the current rating system
- Overall both the CAG and infrastructure positions have deteriorated in month 2. The position continues to be driven by large overspends in the B&D (£1.46m) and Psychosis (£1.28m) CAGs (described in section 3 below and the subject of separate reports to this month’s Board). Together these 2 CAGs represent 68% of the current operational deficit, slightly down on month 1 as other CAG deficit positions have accelerated. These include MAP where the costs of closing the AED service are picking up, Psychological Medicine where the Bethlem Triage Ward’s funding is still to be resolved, MHOA where staffing costs on both wards and continuing care homes are not within funded establishments and Addictions where inpatient activity is below target.
- This position is being partially offset by a phased release of the contingency reserve and the ytd release of £0.66m of provisions but these are not sufficient to fully negate the current rate of overspend
- £4.8m of earmarked funding is held back and not included in the month 2 position including £0.9m for the AMH model and £0.9m for Estate compliance
- In addition the Plan assumes that 100% CQUIN is achieved (compared to c60% in 12/13) and that no KPI sanctions are applied
- Discussions with NHS England to agree a contract for MSU/LSU beds and a range of other specialist services are progressing but not yet agreed. The reported position at month 2 is therefore largely based upon year to date activity at 12/13 prices and is subject to change once final agreement is reached with NHSE

2. **Financial Summary**

<table>
<thead>
<tr>
<th>Service Area</th>
<th>Variance Month 1 £m</th>
<th>Variance Month 2 £m</th>
<th>Variance EBITDA £m</th>
</tr>
</thead>
<tbody>
<tr>
<td>Psychosis</td>
<td>(0.69)</td>
<td>(1.28)</td>
<td>(1.37)</td>
</tr>
<tr>
<td>Behavioural &amp; Dev.</td>
<td>(0.68)</td>
<td>(1.46)</td>
<td></td>
</tr>
<tr>
<td>Mood, Anxiety &amp; Personality</td>
<td>(0.08)</td>
<td>(0.22)</td>
<td></td>
</tr>
<tr>
<td>Psychological Medicine</td>
<td>(0.14)</td>
<td>(0.38)</td>
<td></td>
</tr>
<tr>
<td>Child &amp; Adolescent</td>
<td>(0.08)</td>
<td>0.06</td>
<td></td>
</tr>
<tr>
<td>Older Adults &amp; Dementia</td>
<td>(0.12)</td>
<td>(0.26)</td>
<td></td>
</tr>
<tr>
<td>Addictions</td>
<td>0.00</td>
<td>(0.10)</td>
<td></td>
</tr>
<tr>
<td>Corporate Services</td>
<td>(0.22)</td>
<td>(0.57)</td>
<td></td>
</tr>
<tr>
<td>Corporate Income</td>
<td>(0.01)</td>
<td>(0.05)</td>
<td></td>
</tr>
<tr>
<td><strong>Operational Deficit</strong></td>
<td><strong>(2.01)</strong></td>
<td><strong>(4.27)</strong></td>
<td></td>
</tr>
<tr>
<td>Contingency Reserve</td>
<td>0.50</td>
<td>1.00</td>
<td></td>
</tr>
<tr>
<td>Other Reserves</td>
<td>0.22</td>
<td>0.60</td>
<td></td>
</tr>
<tr>
<td>Corporate Other inc Provisions</td>
<td>(0.08)</td>
<td>0.72</td>
<td></td>
</tr>
<tr>
<td><strong>EBITDA</strong></td>
<td><strong>(1.37)</strong></td>
<td><strong>(1.95)</strong></td>
<td></td>
</tr>
<tr>
<td>Interest/Depreciation/Profit</td>
<td>0.18</td>
<td>0.39</td>
<td></td>
</tr>
</tbody>
</table>
### CAG Issues

#### Psychosis
- Use of acute overspill beds fell by 4 in month 2 but remained at high levels despite the opening of the Bethlem Triage Ward (costing £150k per month – unfunded) and additional investment in key community posts. In May, 31 beds were utilised of which 10 were in Lambeth and 14 in Croydon. The acute overspill overspend of £359k represents 28% of the total CAG ytd overspend. The overall position improved from month 1 due to placement numbers falling and after a review of funding due under the risk share arrangement with Lambeth CCG.
- A further £72k of Swk CCG QIPP has not been met this month (£145k ytd) with the disinvestment in both PICU and acute beds not being offset by reductions in expenditure and/or increases in income. Further work is required to assess use of Trust beds and determine whether other CCGs can be invoiced for over activity.
- Continuing over performance of complex placement activity in Southwark (£158k in the month), particularly use of low and medium secure beds where there has been growth in use of hospital placements over the last 6 months (up a further 3 in May).
- Ward nursing costs came down in month 2 but are still £115k over ytd.
- Low occupancy and a continuing high income target based on opening additional beds on the Psychosis Unit has led to a further £58k shortfall in income this month.
- Despite controls, the drugs budget overspent by £69k in the month (£95k ytd) with the use of paliperidone (costing £150 - £300 per patient per month) continuing the upward trend from 2012/13 and now accounting for c45% of total drug expenditure in the CAG.
- Only £272k of a potential £3.5m of QIPP has been fed into the month 2 position reflecting both the timing and uncertainty around some of the QIPP schemes.
- The overspending position includes £2.89m of annual financial support as per the agreed Plan and a lower CIP target than other CAGs/Directorates proportionate to budget.

#### B&D
- Loss of £3m transitional support, a reduction in the BDU income target and pay inflation have left an unfunded gap of c£3m which is still to be addressed within the Plan.
- Although transitional support has been provided to the NDS service, activity is below the revised plan (by £133k) and pay costs are above the revised plan (by £90k) after 2 months.
- Overall £200k below target on C&V/CPC specialist income – mainly BDU and NDS service.
- A number of CIP schemes (£0.8m) have been re-phased to deliver in the second half of the year which presents a greater risk should they not deliver given the limited time then available to implement corrective action.
- Continuing overspend on Lambeth forensic placements (£248k ytd) where commissioning has transferred to NHS England. This position assumes responsibility for secondary commissioning remains with the Trust.
- Ward nursing costs have remained at levels beyond the revised establishments - £53k over in month 1 and £45k over in month 2.
Currently assuming that NHSE will continue to pay for forensic activity at same £ rates as PCTs in 12/13 but contract has yet to be agreed
• In addition forensic activity in River House is currently c7% below the 95% target set by NHSE. Depending upon the agreement reached with NHSE around tolerances and marginal rates this could have a further adverse impact if this were to continue through the year
• Transitional costs being incurred following the transfer of services from Bridge House – staff redeployment and estate costs

The graph below shows the on-going deterioration in the Psychosis and B&D CAG positions over the last 12 months.

4. Key Cost Drivers

Performance against the main cost drivers is detailed below –

<table>
<thead>
<tr>
<th>Area</th>
<th>12/13 Mth 9 Variance</th>
<th>12/13 Mth 10 Variance</th>
<th>12/13 Mth 11 Variance</th>
<th>12/13 Mth 12 Variance</th>
<th>13/14 Mth 1 Variance</th>
<th>13/14 Mth 2 Variance</th>
<th>13/14 Total Variance</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>£000</td>
<td>£000</td>
<td>£000</td>
<td>£000</td>
<td>£000</td>
<td>£000</td>
<td>£000</td>
</tr>
<tr>
<td>Ward Nursing</td>
<td>(150)</td>
<td>(398)</td>
<td>(159)</td>
<td>(498)</td>
<td>(307)</td>
<td>(174)</td>
<td>(481)</td>
</tr>
<tr>
<td>Acute Overspill*</td>
<td>(315)</td>
<td>(329)</td>
<td>(318)</td>
<td>(432)</td>
<td>(316)</td>
<td>(43)</td>
<td>(359)</td>
</tr>
<tr>
<td>CPC/C&amp;V Income</td>
<td>(362)</td>
<td>(302)</td>
<td>(286)</td>
<td>(224)</td>
<td>(163)</td>
<td>(187)</td>
<td>(350)</td>
</tr>
<tr>
<td>Forensic Placements*</td>
<td>(104)</td>
<td>(247)</td>
<td>(140)</td>
<td>160</td>
<td>(271)</td>
<td>(292)</td>
<td>(563)</td>
</tr>
<tr>
<td>Total</td>
<td>(931)</td>
<td>(1,276)</td>
<td>(903)</td>
<td>(994)</td>
<td>(1,057)</td>
<td>(696)</td>
<td>(1,753)</td>
</tr>
</tbody>
</table>

*excluding impact of risk share and cost of Bethlem Triage

• Acute/PICU Overspill

Overall, 31 beds were used outside the Trust in May, a decrease of 4 compared to the previous month resulting in a year to date net overspend of £359k. The use of Trust beds by CCG is still being reviewed and may result in additional income if activity is above agreed funded levels. A decision regarding the funding of the Triage Ward is still outstanding following submission of an updated business case to the PCT/CCG. The direct cost of the Triage Ward (£289k ytd) is unfunded and this adverse variance is reflected in the overspending position of the Psychological Medicine CAG.
• **Ward/Unit Nursing Costs (Table 3)**

At month 2 ward nursing costs were overspent by £242k (£549k ytd), a reduction from month 1 but still in excess of budget (by 3.3%) with bank costs making up 26% of total pay costs. The top 10 wards highlighted in Table 4 make up 83% of the variance. 5 of the top 10 wards/units now sit within the MHOA CAG.

• **Forensic Placements**

An accelerating overspend of £292k in the month represents a deteriorating position on forensic placements. The commissioning of medium and low secure beds transferred to NHS England from the PCTs on 1st April and the Trust is currently in discussion with NHSE about contracts/risk shares for 2013/14 but as yet no agreement has been reached. The overspend is based upon the funding previously provided by the PCTs and relates particularly to Lambeth and Southwark (a combined overspend of £532k ytd).
• Cost per Case/Cost and Volume Income

The Trust is yet to conclude discussions with NHS England regarding the price/volume and terms and conditions for a range of specialist services in 2013/14 (including low and medium secure beds). The reported position below is therefore based upon 12/13 prices until the basis of a new contract agreement is reached.

Overall the Trust was £350k below target at the end of month 2, the position moved adversely by £187k in May. The majority of the underperformance has occurred in the following areas (similar to last year) –

- Psychosis Unit - £58k shortfall in month 2 (£105k ytd) due in part to an increase in the income target in 2012/13 which reflected the CAGs plan to increase/sell beds on this Unit. The subsequent occupancy level of 77% does not meet the new target set
- The closure of NDS 2 has meant that capacity is no longer sufficient to meet the income targets currently built into the BDP plan resulting in an income shortfall of £133k. In addition the Behavioural Disorders Unit continue to remain below their required target creating an income shortfall of £47k over the last 2 months
- The AED Unit – the impact of running down the Unit in preparation for its closure is impacting on the income variance as activity reduces. The loss at month 2 is £151k
- The Addictions Acute Assessment Unit - £35k deterioration in the month. Occupancy levels of 56% are not sufficient to cover the Unit’s costs despite £0.57m of Trust transitional support

<table>
<thead>
<tr>
<th>CAG</th>
<th>Income Target At Month 2 £'000</th>
<th>Actual Invoiced At Month 2 £'000</th>
<th>Surplus/Deficit At Month 2 £'000</th>
<th>Surplus/Deficit Last Month £'000</th>
</tr>
</thead>
<tbody>
<tr>
<td>Psychosis</td>
<td>623</td>
<td>517</td>
<td>(105)</td>
<td>(47)</td>
</tr>
<tr>
<td>Behavioural &amp; Dev</td>
<td>1,660</td>
<td>1,460</td>
<td>(200)</td>
<td>(54)</td>
</tr>
<tr>
<td>Psychological Med</td>
<td>2,489</td>
<td>2,541</td>
<td>52</td>
<td>59</td>
</tr>
<tr>
<td>Mood and Anxiety</td>
<td>934</td>
<td>765</td>
<td>(170)</td>
<td>(49)</td>
</tr>
<tr>
<td>CAMHS</td>
<td>3,175</td>
<td>3,345</td>
<td>171</td>
<td>(19)</td>
</tr>
<tr>
<td>Addictions</td>
<td>471</td>
<td>374</td>
<td>(97)</td>
<td>(53)</td>
</tr>
<tr>
<td><strong>TOTAL</strong></td>
<td><strong>9,352</strong></td>
<td><strong>9,002</strong></td>
<td><strong>(350)</strong></td>
<td><strong>(163)</strong></td>
</tr>
</tbody>
</table>

The graph below illustrates the overall performance and performance by CAG.
5. **Cost Improvement Programme (CIP) & CCG QIPP**

a) **Trust CIP (Table 5)**

The Trust is reporting an overall adverse variance of £581k (25%) against its original plan of £15.8m at month 2. At month 2, 15% of the savings plan has been phased into the year to date position.

The main areas of variance are highlighted and explained in Table 5. Currently these are linked to the estates rationalisation programme, through not delivering cost improvements following a reduction in MHOA continuing care beds and from a shortfall in the savings required through reductions in sickness, bank/agency costs and other HR driven strategies to offset the 2013/14 pay award. Any delays in delivering the CIP programme, at this early stage in the financial year, will need to be rapidly addressed or compensated for through alternative measures.

b) **CCG QIPP (disinvestment) - Table 6**

There was an overall shortfall of £319k against the CCG QIPP target attributable to SLaM.

The main shortfalls are as per the report last month –

- Some schemes have yet to be agreed with the CCGs but funding has already been removed from the block contract. To date this has only impacted by £66k due to the phasing of schemes. However from month 7, a number of significant schemes in Adult and MHOA services are due to come on stream for which plans are still being developed. These include a review of rehab services, a reduction in acute beds, a review of prescribing and the closure of continuing care beds. If these schemes slip or can’t deliver the scale of savings required then further discussions will be required with the CCGs to determine alternative measures and establish the risk share arrangement in place.

- The reduction in Southwark CCG purchased acute and PICU beds has not been fully offset by lower costs and/or an increase in income from other purchasers of beds (linked in part to the risk share agreements with other local CCGs). Further work to establish the position re CCG use of acute beds is required.

- The retention of Granville Park (and associated costs) by MHOA, pending a review of estate by the CAG which should lead to savings later in the year.

6. **Trust Summary Issues and Actions**

The Trust’s financial position at the end of May is a significant cause for concern as the position continues to deteriorate despite the planned deployment and retiming of the application of reserves in May. The following points are of note:

The overspending pressure in Psychosis remains high even taking account of the timing of the savings due from the Adult Mental Health Transformation programme from October. A separate paper produced by the CAG indicates the varied cause for the over spend and how these can be best addressed. Several of the pressures are of the Trusts making and therefore can be resolved by Management action, however to fully deliver a balanced out-turn at year-end the Board will be asked to support a policy of delivering activity to plan, i.e. the activity levels agreed with the commissioners. The implications of this more active management of access to services for patients, the public and the Trust will need to be more fully understood.
The overspending pressure in BDP also remains high partially because the Transformation Plan is not due for consideration by the Board till June. Again, a separate paper from the CAG indicates the varied causes for the over spend, including activity and in particular the number of placements made for both particular clinical reasons and over spill. To fully deliver a balanced out-turn at year-end with the already earmarked use of some £1.4m of support, the Board will be asked to support a policy of delivering activity to plan, i.e. the activity levels agreed with the commissioners. The implications of this more active management of access to services for patients, the public and in this instance the Ministry of Justice will need to be more fully understood.

Although other over spend are containable the pressures in Estates are of note and although they in the main relate to "legacy issues", e.g. un delivered previous years cost improvements, over use of agency staff, it is suggested to the Board that a more detailed understanding of the issues and actions to address these issues should be considered in July.

The contract with the Specialist Commissioner is now nearing closure (which may be achieved by the date of the Board). The financial risk with this contract has reduced from a figure of some £4m in April to no an estimated value of £1.5m. The risk is coverable from the contract element of the contingency reserve, though this will further put pressure on all CAGS to deliver budget balance by year-end.

One other significant reputational concern is that the financial plan submitted to Monitor showed significant savings delivery in quarters three and four (AMH and BDP transformation). However the plan brought the Trusts FRR rating close to the boundary of a Financial Risk Rating of a low 2 during Quarters 1 and 2. The current over spend probably will push the Trust to a low risk rating of 2 for Quarter 1.

The following key actions are recommended to the Board:

- That the Psychosis over spend paper is considered and approval given to actions within it and a break-even trajectory from Month 3 – Month 12 is agreed and closely monitored.
- That the BDP over spend paper is considered and approval given to actions within it and a break-even trajectory from Month 3 – Month 12 is agreed and closely monitored.
- That an over spend analysis and action plan paper is requested from Estates for the July Board.
- That all support is given to concluding contract discussions with the Specialist Commissioners at the end of June and to support representations to the NHS Commissioning Board if the suggested contract shows any more than a net 4% reduction in value from 2012/13 (i.e. the CIP reduction).
- That at the July Board meeting if Croydon CCG fails to commission the additional Triage Ward (currently open at risk), that the Trust would reduce commissioned bed numbers to the level stipulated in the CCG contract and recover any over spend incurred over that later months of the year.
- That every effort is made to protect the financial risk rating of 3 at quarter one by careful attention to income and expenditure phasing, the correct representation of provisions and the management of discretionary spend activity.

In summary the finances of the Trust are under pressure with insufficient reserves available to offset all these pressures. Prompt and supported management action should deliver a balanced out-turn, however the Trust will increasingly need to "work to contract" to avoid carrying the significant financial pressures of activity and the acuity of that activity running significantly above commissioned levels.
Net deficit of £1.5m was £1.5m below Plan at the end of May. This includes an operational deficit of £4m caused by overspends in the majority of CAGs, particularly Psychosis and B&D. The operational deficit is being partially offset by the Trust contingency reserve and other non recurring items but these are not sufficient to fully negate the current rate of overspend.
TRUST BOARD - SUMMARY REPORT

Date of Board meeting: 25th June 2013

Name of Report: Chief Executive’s report

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

Author(s): Paul Mitchell, Trust Board Secretary

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

Presented by: Gus Heafield, Acting Chief Executive

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

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

Recommendations to the Board:
To note the report.

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

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

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

June 2013

1. National issues

**New Academic Health Science Networks announced**
NHS England has confirmed the designation of 15 new Academic Health Science Networks (AHSNs) which pull together innovation with clinical research and trials, informatics, education, and healthcare delivery. AHSNs will develop solutions to healthcare problems and get existing solutions spread more quickly through strong relationships across scientific and academic communities. SLaM is part of the South London AHSN.

**Sir David Nicholson announces plan to retire from NHS**
NHS England has announced that Sir David Nicholson has decided to retire from the NHS, and as Chief Executive of NHS England, in March 2014. Sir David has worked in the NHS for 35 years in over 14 organisations covering all care groups and parts of the NHS. He was NHS Chief Executive for almost seven years and in October 2011 agreed to become Chief Executive of the NHS Commissioning Board, now known as NHS England.

2. Trust and IoP issues

**New Maudsley learning centre opens**
The new learning and events centre opened at the start of June and will provide world-class facilities for staff to use for meetings, events and conferences.

It will offer more than 1500sqm of flexible learning space, with a number of meeting rooms, an open plan foyer, a café, wifi access and landscaped gardens all spread over seven floors. A range of learning opportunities and events will be available for a variety of audiences - SLaM and IoP staff, service users, carers. The centre will also be made available to the wider community, which will help promote messages on positive mental health and wellbeing.

The project has been funded by the Maudsley Charity and was delivered on time and on budget. The new centre will be operated by Maudsley Learning, a Community Interest Company which has been established as a subsidiary of the Charity.

**Integrated Care : Model of change**
The Government is encouraging collaboration between local partner organisations to set out an ambitious vision of making person-centred coordinated care and support the norm across the health and social care system in England over the coming years. The recently published *Integrated Care and Support: Our Shared Commitment* signals how this national partnership will work together to enable and encourage local innovation, address barriers, and disseminate and promote learning in support of better integration for the benefit of patients, people who use services, and local communities.

The national partnership is therefore inviting expressions of interest from local areas to become integration ‘pioneers’ as a means of driving forward change at scale and pace, from
which the rest of the country can benefit. We are looking for pioneers that will work across
the whole of their local health, public health and social care systems and alongside other
local authority departments and voluntary organisations as necessary, to achieve and
demonstrate the scale of change that is required.

Southwark and Lambeth Integrated Care will be bidding to attain Pioneer Status, as part of
the government’s initiative to encourage, support and promote 10 sites across the UK in
order to showcase genuinely innovative integrated care provision. It is important that that
SLaM is an active partner in this bid but I am conscious that the timescale is very tight and
some of the detail will need to be worked up as part of the planning and submission process
with proper opportunities for sign-off by the Boards of the partners in the Integrated Care
Programme.

3. Chief Executive Performance Management Review

The June CE PMR meetings will be held after the production of the Board papers. A verbal
update on the key themes of the meetings will be made.

4. Information Governance

Following the publication of the national Information Governance (Caldicott 2) Review led by
Dame Fiona Caldicott, the Information Governance Team undertook a thorough review of
the report to ensure that the recommendations arising from the review is incorporated in the
Trust’s annual information governance action plan to ensure continued compliance with
good practice standards. There were a number of awareness sessions to ensure that staff
who have direct responsibility for information governance in the Trust are aware of the
recommendations, including a briefing session at the Trust Caldicott Committee meeting.

The Trust Caldicott Committee has signed off the information governance action plan with
recent updates. The plan includes a detailed assurance programme of independent and
internal audits, an improved awareness and training programme and review of information
governance related policies and procedures. The focus is to maximise the secure,
confidential and ethical utilisation of clinical information held by the Trust for research and
service improvement.

Gus Heafield
Acting Chief Executive
June 2013

Z / Board / meeting 2013 06 25 / Chief Executive report June 13
TRUST BOARD OF DIRECTORS – SUMMARY REPORT

Date of Board meeting: 25th June 2013

Name of Report: Report from the Council of Governors

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

Author: Paul Mitchell, Trust Board Secretary

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

Presented by: Noel Urwin, Vice Chair, Council of Governors

Purpose of the report:
To update the Board on the current areas of Council of Governors activity.

Action required:
To note.

Recommendations to the Board:
To note.

Relationship with the Assurance Framework (Risks, Controls and Assurance):
The Council of Governors is an integral component of the Trust’s Constitution as a Foundation Trust.

Summary of Financial and Legal Implications:
Budgetary provision has been made to support the activities of the Council of Governors.

Equality & Diversity and Public & Patient Involvement Implications:
The Council of Governors has a responsibility to ensure that the Trust’s membership is representative of the local populations in terms of diversity and that all members, including those from the patient & public constituencies, are fully involved.
1. Constitution review

A paper proposing a number of changes to the FT Constitution was considered and agreed at the meeting of the Council of Governors and Board of Directors. If approved, these will be sent for consultation with the membership in July prior to final approval at the annual members’ meeting in September.

2. Report from the Nominations Committee

2.1 Recruitment of up to two Non-Executive Directors

It was recommended that steps should be put in place to recruit up to two Non-Executive Directors. Professional skills and experience would be particularly sought in:

- business development/marketing
- clinical or academic research

A fuller brief would be worked up further by the Committee.

Lessons should be learned from the recent recruitment process particularly in the use of the internet and social media. Guidelines to be issued by the Trust Board Secretary.

2.2 Re-appointment of Robert Coomber

Robert Coomber is due to come to the end of his present term as a Non-Executive Director on the Foundation Trust Board on 30th June 2013. He has been an active Non Executive Director, particularly in his role as Chair of the Audit Committee and through his participation in the Activity and Finance Committee.

The Chair’s review of the performance has been concluded and endorsed Robert Coomber’s continued ability to contribute to the Board in the light of the knowledge, skills and experience required. His combination of financial skills and local knowledge would be difficult to replace.

The Nominations Committee recommended the reappointment of Robert Coomber for a period of up to three year term as a Non Executive Director to the next meeting of the Members’ Council. This was agreed unanimously by the Council of Governors.

2.3 Appraisal of the Chair

The Nominations Committee has met every year since 2007 and considered the outcome of the process for the Chair’s appraisal which has been conducted by independent consultants – initially by KPMG, and subsequently by Debbie de Haas from Renew Consulting.
This process is both more independent and more robust than the guidance set out in the Monitor Code of Governance. That guidance suggests the Chair’s appraisal be conducted by a ‘Senior Independent Director’ – one of the Non-Executive Directors on the Board of Directors. Instead, every year, the Nominations Committee has reviewed performance on the basis of feedback obtained independently from a wide range of stakeholders, including members of the Council of Governors, Non-Executive and Executive Board Directors and senior figures from other organisations with which the Trust works closely, for example other NHS Foundation Trusts, commissioners, academic partners and the Foundation Trust Network. The individuals consulted are varied from year to year so that a comprehensive and dynamic picture is obtained.

The Council of Governors noted that this process will be continued for the Chair’s appraisal in 2013.

3. Membership and communications

The process to hold by-elections to fill the current ten vacancies on the Council of Governors commenced on 28th May and will conclude on 26th July. The following nominations have been received:

**Staff** (2 vacancies):
- Yvonne Barrett
- David Blazey
- Iyone Ranasinghe
- Tom Werner

**Service Users (local)** (3 vacancies):
- Christopher Anderson
- Christopher Collins
- Michael Glyn
- Nashiru Momori

**Service Users (national)** (3 vacancies):
- None

**Carer** (2 vacancies):
- Matthew McKenzie

This year the key external presence for membership awareness will be at the Lewisham Peoples’ Day on 13th July.

4. Joint Governors meeting

The next joint Governors meeting will be held on Thursday, 18th July 2013 at the new Maudsley learning centre. A programme will be circulated nearer the time.

Paul Mitchell
Trust Secretary
June 2013
TRUST BOARD OF DIRECTORS – SUMMARY REPORT

Date of Board meeting: 25th June 2013

Name of Report: Changes to the FT Constitution

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

Author: Paul Mitchell, Trust Board Secretary

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

Presented by: Gus Heafield, Acting Chief Executive

Purpose of the report:
To receive proposals for changes to the FT Constitution.
This paper has been discussed and agreed by the Council of Governors (Members’ Council).

Action required:
To consider the recommendations and confirm the ongoing process:
1. Issue agreed recommended changes for consultation to the SLaM membership in July 2013.
2. Delegate responsibility for drafting agreed amendments to the constitution to the Trust Board Secretary.
3. Present to the general members’ meeting for approval in September 2013.

Recommendations to the Board:
To agree the recommendations and confirm the ongoing process.

Relationship with the Assurance Framework (Risks, Controls and Assurance):
The Foundation Trust’s Constitution is the key document that regulates the governance of the Foundation Trust.

Summary of Financial and Legal Implications:
The commencement orders relating to the Health and Social Care Act 2012 (H&SCA) pass responsibility for approving the Constitution to the Board of Directors and Council of Governors. The Constitution has also to be adopted at a APM or general members’ meeting.

Equality & Diversity and Public & Patient Involvement Implications:
The proposals will be subject to a consultation process with the Trust’s members prior to consideration at the Annual Public Meeting.
Review of FT Constitution

1. Introduction

The Foundation Trust’s Constitution is the key document that regulates the membership, election of governors and the appointment of Non Executive Directors and the Chief Executive. The commencement orders relating to the Health and Social Care Act 2012 (H&SCA) pass responsibility for approving the Constitution to the Board of Directors and Council of Governors. The Constitution has also to be adopted at a general members’ meeting.

A paper was brought to both the meetings of the Board of Directors and the Council of Governors in September 2012 proposing a two stage approach to amending the Constitution.

- Stage 1 – carry out the changes required as a result of changes to the Monitor model Constitution. Authority to complete was delegated to the Acting Chief Executive and Trust Secretary by 1st October 2012 and agreed by the Trust Chair. These changes have since been approved by Monitor
- Stage 2 – carry out a wider review of the FT Constitution making recommendations to meetings of the Board of Directors and Council of Governors.

2. Changes to the current Constitution

2.1 Name - Council of Governors (Members’ Council)
The name “Members’ Council” has been applied since FT authorisation in November 2006. As a result of the passing of the Health and Social Care Act 2012 all governing bodies are referred to as Councils of Governors. As this was reflected in the Monitor core Constitution these changes have already been made at stage1 (above).

It is proposed that the SLaM governors’ body is referred to as Council of Governors (Members’ Council).

2.2 Size of the Council of Governors (Members’ Council)
There are currently 26 elected and 13 nominated governors plus the Chair which makes for a governing body of 40. Whilst it is important to retain a body that is of a size to be effective in making decisions, there appears to be no appetite to change the size of Council of Governors (Members’ Council).

2.3 Commissioning arrangements
Changes in the organisation of the NHS as a result of Health and Social Care Act 2012 have led to the abolition of the four local Primary Care Trusts and NHS London all of which had nomination rights to the Council of Governors (Members’ Council).

It is recommended that the successor bodies (Lambeth CCG, Southwark CCG, Lewisham CCG, Croydon CCG and NHS England [London]) are offered the opportunity to nominate representatives to the Council of Governors (Members’ Council).
2.4 Commercial activities
The phraseology used to describe commercial activity is “non principal purpose activities” and these require governor approval for planned increases of more than 5%. It is recommended that this should be reflected in the Constitution.

2.5 Significant transactions
The H&SCA gives Trusts the option of defining significant transactions. The current definition set out by Monitor is that transactions representing in excess of 25% of gross assets require approval by governors. It is recommended that this should be reflected in the Constitution.

2.6 Rest of England and Wales constituencies
The FT has divided its patient and public constituencies between local (Lambeth, Southwark, Lewisham and Croydon) and the rest of England and Wales. Whilst it has been possible to recruit sufficient numbers of members to stand for election in the public constituency (Rest of England and Wales) it has proved to be difficult to encourage service users to stand in the patient (Rest of England and Wales) constituency. Indeed, the Trust has been carrying three vacancies for over three years. It is recommended that the distinction between local and national is abolished so that there is just one constituency for patients (nine places) and public (eight places).

3. Recommendation for action

3.1 Take to the respective meetings of the Council of Governors (Members’ Council) and Board of Directors in June 2013.

3.2 Issue agreed recommended changes for consultation to the SLaM membership in July 2013.

3.3 Delegate responsibility for drafting agreed amendments to the Constitution to the Trust Secretary.

3.4 Present to the general members’ meeting for approval in September 2013.

Paul Mitchell
Trust Secretary
May 2013
### TRUST BOARD OF DIRECTORS – SUMMARY REPORT

<table>
<thead>
<tr>
<th>Date of Board meeting:</th>
<th>25th June 2013</th>
</tr>
</thead>
<tbody>
<tr>
<td>Name of Report:</td>
<td>Safeguarding Children Arrangements Declaration of Compliance</td>
</tr>
<tr>
<td>Heading:</td>
<td>Quality</td>
</tr>
<tr>
<td>Author:</td>
<td>Matt Beavis</td>
</tr>
<tr>
<td>Approved by: (name of Exec Member)</td>
<td>Dr Jane Sayer</td>
</tr>
<tr>
<td>Presented by:</td>
<td>Matt Beavis</td>
</tr>
</tbody>
</table>

**Purpose of the report:**
To provide assurance to the Board that the Trust is compliant with the legal requirements for Safeguarding Children and to update the Board following the Declaration presented to the Board in March 2013

**Action required:**
To receive the report

**Recommendations to the Board:**
To note the report

**Relationship with the Assurance Framework (Risks, Controls and Assurance):**
Working Together to Safeguard Children (2013), and London Child Protection Procedures (2010), Care Quality Commission Outcome Seven (“Safeguarding People Who Use Services From Abuse”) and Monitor

**Summary of Financial and Legal Implications:**
Children Act (1989 and 2004)

**Equality & Diversity and Public & Patient Involvement Implications:**
Safeguarding Children has implications for young service users and the public, and requires public and patient involvement to ensure improvements in delivering equitable and safer care to children who access our services and who live within our local services.
South London and Maudsley NHS Foundation Trust

Safeguarding Children Arrangements
Declaration of Compliance

June 2013

The South London and Maudsley NHS Foundation Trust is committed to safeguarding children across the organisation. This is reflected in the Trust's Safeguarding Children Strategy which sets out the Trust's vision for safeguarding children ensuring that safeguarding and promoting the welfare of children is embedded across every part of the Trust and in every aspect of its work.

Children and young people are considered in all interactions with service users and their carers. The welfare of children is the paramount consideration of all staff across the Trust and guides their work. All staff whether permanent, temporary or contracted have a duty to ensure that children are protected from harm and comply with the principles laid down in the Children Acts (1989 and 2004), Working Together to Safeguard Children (HM Government 2010), and London Child Protection Procedures (2010).

Work to strengthen and improve safeguarding children arrangements is ongoing within the South London and Maudsley NHS Foundation Trust. This is an important area for the organisation and, following the publication of the Care Quality Commission (CQC) report into arrangements in the NHS for safeguarding children (2009), the Trust has regularly reviewed its own arrangements against priority areas highlighted by the CQC and Monitor (the independent regulator of NHS Foundation Trusts). As a result of this review the Trust is satisfied that the following arrangements are in place:

- **Criminal Records Bureau (CRB) Checks**
  - The South London and Maudsley NHS Foundation Trust meets the statutory requirements with regard to the carrying out of Criminal Records Bureau (CRB) checks. The Trust has a fully implemented CRB checks policy in place. The policy sets out the criminal records checks which the Trust will undertake for the appointment and ongoing employment of all relevant individuals within the Trust. The policy complies with the NHS employment check standards. The Trust ensures that all staff undertaking regulated activity have the required enhanced level of CRB check with these checks systematically updated every three years.

- **Policies**
The South London and Maudsley NHS Foundation Trust safeguarding children policies and systems were reviewed in line with amendments to “Working Together to Safeguard Children” (2010) and the “London Child Protection Procedures” (2010), including a process for following up all children who miss outpatient appointments and a system for flagging children for whom there are safeguarding concerns.

The Trust’s safeguarding children policy and procedures are available on the Trust Safeguarding Children Intranet site within the same “Guidance” section as the national and pan-London guidance in order to improve consistent and timely staff access. A Trust “Flowchart” for immediate action to address concerns for a child’s safety has been developed and is found on the front page of the site.

The Trust safeguarding children policies will be formally reviewed and revised following the publication of the forthcoming revised “Working Together to Safeguard Children” national guidance as a result of recommendations from the Munro Review of Child Protection. Prior to publication of this revised national guidance Trust staff are directed to follow current national and pan-London guidance (“Working Together to Safeguard Children” (2010) and the “London Child Protection Procedures” (2010)) as displayed clearly on the “Guidance” section of the Trust Safeguarding Children Intranet Site. The review plans are reflected on the same page of the Intranet site as the current Trust policies and national and pan-London guidance.

Accessibility of Information, Support and Guidance

The Trust Safeguarding Children Intranet Site has been further developed and redesigned to increase accessibility and support staff in their safeguarding practice and decision-making. The site has been received positively internally, when presented externally to Local Safeguarding Children Boards and via formal external Ofsted and CQC Announced Safeguarding and Looked After Children Inspection during 2012.

All clinical services have access to Trust and local safeguarding children lead individuals as well as posters and leaflets giving sources of advice and referral in safeguarding children matters including those to be used out of hours.

Training

The Trust provides a combined level 1 and 2 safeguarding children training session to all staff during their induction to the organisation and has kept staff appropriately updated. In addition Level 3 training has historically been provided internally and by partner Local Safeguarding Children Boards to staff who work predominantly with children, young people and parents.

As the Intercollegiate Document (which guides health organisations in the type, amount and frequency of training required by its various staff groups)
has been reviewed and amended Trusts are advised that all staff working with service users within mental health organisations should be trained to level 3. The Trust has undertaken a further review of its training and has discussed how best to meet requirements both internally and with the Care Quality Commission (CQC) and Local Safeguarding Children Boards (LSCB’s).

- The Trust percentage training completions as reported by the Trust Education and Training Department in October 2012 illustrated that:
  - 92% of eligible staff are up to date with Level 1 training
  - 85% of eligible staff are up to date with Level 2 training
  - 63% of eligible staff are up to date with Level 3 training

- The Trust will commence team-based level 3 safeguarding children training from April 2013 which will increase completion rates and individual and organisational learning via the delivery of annual level 3 updates to all clinical teams Trustwide. The rationale for this approach is based on Trustwide feedback, research, listening events and consultation into what will increase individual and organisational learning (and therefore fully embraces the strategic aims of the Academic Health Science Centre of closely aligning and informing clinical practice with increased focus on research and academic development). The new model has also been discussed with the CQC (Care Quality Commission) CCG’s (Clinical Commissioning Groups) and LSCB’s (Local Safeguarding Children Boards). It is designed to more efficiently and effectively disseminate and embed safeguarding children learning in practice.

- Governance

  - The Trust’s current safeguarding children arrangements have been viewed as working well during the period of 2012-2013 with internal and external audits and inspections including:
    - Annual Section 11 Audits
    - LSCB Multi-Agency Audits
    - Annual Trust Practice Audits
    - Annual Trust Clinical Records Audit
    - CQC Visits’ (and Mock Visits’) Focus on Outcome Seven (“Safeguarding People Who Use Services From Abuse”)
    - Announced Ofsted / CQC Inspections of Safeguarding and Looked After Children (2012)
    - CAMHS Supervision Audit

- Child Need and Risk Screen

  - The Trust requires completion of a Child Need and Risk Screen for all adult service users and for young people who may have dependant children of
their own. This is completed as part of ongoing assessment to identify the existence of dependant children, contact with other children and determine levels of risk and unmet need.

- Completion rates are monitored and performance-managed on a monthly basis by the Board of Directors as part of the quality report and are discussed at both the CEO Performance Management Meeting and Trust Safeguarding Children Committee. The following illustrates the percentage completion rates across the Trust’s Clinical Academic Groups over the last year:

<table>
<thead>
<tr>
<th>Child Risk Screen</th>
<th>Apr-12</th>
<th>May-12</th>
<th>Jun-12</th>
<th>Jul-12</th>
<th>Aug-12</th>
<th>Sep-12</th>
<th>Oct-12</th>
<th>Nov-12</th>
<th>Dec-12</th>
<th>Jan-13</th>
<th>Feb-13</th>
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</thead>
<tbody>
<tr>
<td>CAGs</td>
<td>Target to be met</td>
<td>100%</td>
<td>96%</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Addictions</td>
<td>%</td>
<td>%</td>
<td>%</td>
<td>%</td>
<td>%</td>
<td>%</td>
<td>%</td>
<td>%</td>
<td>%</td>
<td>%</td>
<td>%</td>
</tr>
<tr>
<td>97.75. %</td>
<td>97.98. %</td>
<td>98.14. %</td>
<td>98.12. %</td>
<td>97.89. %</td>
<td>97.89. %</td>
<td>97.61. %</td>
<td>97.54. %</td>
<td>97.60%</td>
<td>97.60%</td>
<td>97.49%</td>
<td></td>
</tr>
<tr>
<td>Behavioural and Developmental Psychiatry</td>
<td>83.19. %</td>
<td>83.18. %</td>
<td>82.89. %</td>
<td>82.55. %</td>
<td>82.77. %</td>
<td>83.17. %</td>
<td>83.19. %</td>
<td>83.10. %</td>
<td>83.29%</td>
<td>83.30%</td>
<td>83.08%</td>
</tr>
<tr>
<td>Child and Adolescent Mental Health Services</td>
<td>N/A</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
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</tr>
<tr>
<td>MHDA and Dementia</td>
<td>95.98. %</td>
<td>95.47. %</td>
<td>95.28. %</td>
<td>95.72. %</td>
<td>95.36. %</td>
<td>95.13. %</td>
<td>94.61. %</td>
<td>94.41. %</td>
<td>94.37%</td>
<td>93.76%</td>
<td>93.61%</td>
</tr>
<tr>
<td>Mood Anxiety and Personality</td>
<td>94.38. %</td>
<td>94.55. %</td>
<td>94.26. %</td>
<td>94.49. %</td>
<td>94.26. %</td>
<td>94.27. %</td>
<td>94.28. %</td>
<td>94.16. %</td>
<td>93.91%</td>
<td>93.81%</td>
<td>93.64%</td>
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<tr>
<td>Psychological Medicine</td>
<td>93.52. %</td>
<td>93.28. %</td>
<td>93.26. %</td>
<td>92.97. %</td>
<td>92.47. %</td>
<td>92.26. %</td>
<td>92.04. %</td>
<td>91.99. %</td>
<td>91.62%</td>
<td>91.26%</td>
<td>91.18%</td>
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<tr>
<td>Psychosis</td>
<td>97.40. %</td>
<td>97.34. %</td>
<td>97.33. %</td>
<td>97.29. %</td>
<td>97.45. %</td>
<td>97.52. %</td>
<td>97.42. %</td>
<td>97.30. %</td>
<td>97.09%</td>
<td>97.07%</td>
<td>96.92%</td>
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<tr>
<td>Totals</td>
<td>93.75. %</td>
<td>93.67. %</td>
<td>93.55. %</td>
<td>93.55. %</td>
<td>93.44. %</td>
<td>93.41. %</td>
<td>93.24. %</td>
<td>93.11. %</td>
<td>92.94%</td>
<td>92.74%</td>
<td>92.93%</td>
</tr>
</tbody>
</table>

- The Trust Child Need and Risk Screen has received positive external feedback based on its required increased focus on the child. The Trust has recently reviewed the tool itself to ensure that it is as helpful and effective as possible for professionals completing it. As well as listening to and acting upon feedback from clinicians and responding to lessons learned from Serious Case Reviews the review has proposed:
  - Increased text boxes to allow staff to account for decisions made in the safeguarding of the child
- A link to the Trust Safeguarding Children Intranet Site to support staff in its completion and consideration of safeguarding issues within the assessment.
- The addition of a direct question regarding whether the completion of the screening tool has led to a child protection referral to the relevant Local Authority Children Social Care Team and how this referral has been followed up by both organisations.

This section also advises staff how to obtain support in the event of a need to escalate safeguarding concerns. This system is designed to support practice and also compliment the team and Clinical Academic Group’s referral monitoring responsibilities and to ensure a safe and consistent approach to all cases requiring safeguarding and protection of children.

- The new Child Need and Risk Screen Tool was formally uploaded to ePJS (Trust electronic patient records system) in December 2012 and following some initial unexpected technical issues will re-launch in April 2013 with the technical issues resolved.

### Roles and Responsibilities

- The South London and Maudsley NHS Foundation Trust continues to have named professionals who lead on issues in relation to safeguarding children. They are clear about their role, have sufficient time and receive relevant support and training to undertake these roles. The total number of professionals in these roles is two.

- Their disciplines are as follows:
  - Named Doctor Safeguarding Children – Senior Consultant Psychiatrist - 1 session/week protected time for safeguarding children
  - Named Nurse Safeguarding Children - Band 8 - employed full time

- The Trust’s Director of Nursing and Education is currently the Executive Lead for Safeguarding Children and chairs the Trust Safeguarding Children Committee which reports to the Board of Directors on safeguarding children via the Trust Risk Management Committee.

  From 1st April 2013, in her capacity as Acting Director of Nursing and Education, Dr Jane Sayer, replaced the departing Director of Nursing and Education, Professor Hilary McCallion as the Executive Lead for Safeguarding Children.

- The future reporting lines are less clear currently with the Trust yet to formally declare where safeguarding children (and adults) will report. In the interim period the Assistant Director of Nursing Trust Named Nurse Safeguarding Children has been asked to complete a scoping exercise of Trust safeguarding adults arrangements. He is currently the Trust representative on
all boroughs Local Safeguarding Children Boards and has, as part of the
scoping exercise, agreed to represent the Trust at all Local Safeguarding
Adults Boards; as well as co-ordinating and providing Trust representation at
the local Clinical Commissioning Groups’ (CCGs) quarterly safeguarding
(children and adults) monitoring meetings.

- The Trust Board has robust audit programmes to assure it that safeguarding
systems and processes are working. These are regularly shared and
discussed with Local Safeguarding Children Boards.

- The Trust Board takes the issue of safeguarding extremely seriously and
receives an annual report detailing the safeguarding children issues in place
across the organisation. The last Annual Report was presented on the 11th
September 2012. It also receives an annually updated Declaration of
Compliance. The last Declaration was presented to the Trust Board on 26th
March 2013; with the Board requesting an amended version containing more
qualitative narrative reference to the impact of Trust safeguarding children
arrangements. The following section will provide this.

- The Safeguarding Context

- Given the nature of safeguarding and protecting children there will always be
challenges involving abusive and neglectful acts of maltreatment. The cases
that we deal with are never (and can never be) viewed as being straight
forward as they relate to children, families and human behaviour; which can
in many cases be predicted and engaged by good assessment of unmet
need and risk; but which, at other times, will see less predictable human
responses and behaviours.

- Human beings (staff and service users alike) do not always do the “right”
thing.

- As part of our Trust safeguarding children arrangements we have attempted
year-on-year to challenge what we do and how we do it in terms of the
system we provide for staff to enable high quality safe and responsive
practice. This is why we review our arrangements; assertively involving staff
in the arrangements we require them to observe in their practice. We
therefore constantly strive to create a system, tools and a clinical
environment that enables professional judgement and empowers and
supports staff to do right; whilst making it harder for them to do wrong.

- Current Challenges and Responses

- We are continually challenging all elements of our safeguarding children
arrangements, striving to ensure that they are ever more embedded in day-
to-day practice. The past year’s reviews (with full staff involvement and
consultation; and based on Trustwide research, feedback and lessons
learned from Serious Case Review) and revisions of the Child Need and Risk
Screen, training strategy and model and Domestic Violence Policy and care
pathways are all reflective of the strengthening of these Trust safeguarding arrangements.

- **Participation in Governance Structures**

  - There continue to be challenges; both to our ways of working and also in terms of the safeguarding issues that clinical staff are facing in practice. Given that the Trust safeguarding children arrangements rely on embedding in practice and consistent team-based structures and consciousness it is vitally important that there is the organisational drive through to team-based practice and awareness.

  - Whilst we have a strong safeguarding assurance and governance structure; with Borough Safeguarding Children Committees reporting to the Trust Safeguarding Children Committee, which reports to the Board via the Risk Management Committee; the Trust needs Clinical Academic Groups (CAG’s) and their services to ensure active participation and representation in these local borough committees.

  - It has recently been necessary to escalate to the Trust Risk Management Committee the fact that attendance from the CAG’s services has been worryingly low across many of the boroughs. Borough and CAG safeguarding children leads in each borough are currently working together to find solutions to increase attendance and active involvement. This will be monitored via the Trust Safeguarding Children Committee.

- **Contribution to Child Protection Conferences**

  - We understand the importance of our involvement in multi-agency child protection conferences which is why we systematically receive all invitations to conferences from each Local Authority with the local Trust Safeguarding Lead checking Trust involvement and, if the case is known to Trust services, informing the care coordinator by email of the need for them to; attend the conference, inform the Child Protection Plan and send the conference a report to inform its actions. This is a good and robust system as long as care coordinators do engage in the process. Where this has not happened we have seen missed opportunities to fully safeguard and protect; with a recent Serious Care Review highlighting a lack of care coordinator representation and team-based management oversight of this process resulting in a reduced effectiveness of multi-agency communication and collaboration; and a worse outcome for a child.

  - This, as with all learning, is being followed up by the Trust Named Nurse Safeguarding Children and borough safeguarding children lead in the form of a team-based session reflecting on learning, practice and a plan of action moving forward. The case has also been added as one of the scenarios for case discussion and dissemination of learning in our new Trust team-based safeguarding children level 3 training update which all clinical teams will receive over the next year. We are also asking Local Authorities via Local Safeguarding Children Boards to ensure that we are informed by Child
Protection Conference Chairs if any of our care coordinators are not participating actively in these vitally important multi-agency protection forums.

- **Inter-Agency Communication, Collaboration and Information-Sharing**

  - We are also working with Local Safeguarding Boards and partner agencies to create more opportunities for front-line direct care staff to meet, better understand the strengths and limitations offered by each organisation and enable improved inter-agency communication, collaboration and information sharing.

  - With a focus on early help for children and families we hope that a strengthening of connection of staff across the partnerships will better address the common pressures of; services more stretched by financial constrains with fewer resources, increasing caseloads and rising thresholds determining the levels of interventions offered.

  - This will be centred, with the rest of our engagement with partner organisations, on continued, practical implementation of the “Think Family” agenda and ensuring that we help our staff to see the children and adults in our care as part of a family unit. Our focus is, where possible, on early intervention to meet need; as well as the times when we need to protect.

  - Much of the safeguarding work we do is complex, multifaceted and by no means clear cut. We are finding that our staff, through being more aware and informed of both their duties to safeguard and of the Trust arrangements to support them, are contacting our Trust Advice Line and requesting advice and consultation via this and their local Trust Safeguarding Leads. As a result we see a rising awareness of Domestic Violence and the impact on victims and their children. We have strengthened our policy and care pathways giving staff a single route to borough-based domestic violence specialist services. This will support practice but staff still face challenges of disclosures not made or made and then retracted by victims worried about the impact on them and their safety if they are supported by services to take more assertive action.

  - We have seen an increase in historical allegations of childhood sexual abuse and exploitation over the last year due, we feel, in part to the increased awareness through high profile cases that there can be action by police and social care years after the abuse to address the original crime and also to protect children who may continue to be at risk by perpetrators of sexual abuse and exploitation. We are supporting staff to actively follow these disclosures up. We have also seen an increase in advice calls regarding historical allegations of abuse from staff in our Trust IAPT services. We feel that this is a reflection of adult service users, through their improved access to psychological therapies, talking maybe for the first time to a professional about things that have happened to them in their lives that have negatively affected their mental health. Whilst this is not good in terms of what people have experienced, the fact that these disclosures are being made and acted upon by services is positive.
We have also noted that our IAPT services use the Trust Advice Line probably more than any other of the Trust services. The calls invariably refer to an assessment they have completed, some concerns that they have identified regarding the safeguarding of children, the fact that they have taken these concerns to supervision and that they are now contacting us as Trust safeguarding children leads for further advice to determine a plan of action. With the advice given and the plan formulated they follow the plan through (often in the form of referral to Children’s Social Care) document fully and inform us of the outcome for the child. They often do this following one-off assessments that will not necessarily be seen for follow-up in their service but will ensure information is proportionately shared with agencies/professionals who will have ongoing contact with the individual and their family.

This is the process that we would want and expect our services to follow (i.e. early identification through initial assessment, formulation of risk, discussion within the multi-professional team, management oversight and discussion in supervision, formulation of plan of action with, if required, consultation with Trust Named and Lead Safeguarding professionals and onward referral and proportionate information sharing to meet need and reduce risk; thus improving outcomes for children, young people and families.

IAPT are not alone in this good practice (which is widespread across the Trust) but they are used on this occasion as an example from our records of advice calls of what we think “good” looks like; as there is learning to be taken from safe, consistent and effective practice as well as when the process, system and practice has not been enacted as well which we tend more to focus on through our involvement in Serious Case Reviews, Serious Untoward Incidents, Structured Investigations, Board Level Inquiries, Complaints and Allegations Against Staff. There has to be a balance and also some examples for staff of what good, safe and effective practice is as well as just examples of poor practice.

The audits, inspections and Trustwide research suggest that there is a good level of awareness and assertive response by Trust staff in meeting the safeguarding needs of children and young people; but the Trust will continue to challenge its arrangements, staff understanding of these arrangements and their impact on outcomes for children and young people through robust internal and external scrutiny; continuing to clarify expectations and further embed safe principles in practice. With this in mind we are now asking our Trust safeguarding leads to regularly appraise us of the key strengths and concerns within their boroughs and what is being done to address concerns or gaps in assurance in order to ensure that we respond quickly and assertively in the best interest of children and young people.

Dr Jane Sayer
Acting Director of Nursing and Education
Executive Lead for Safeguarding Children

Matt Beavis
Assistant Director of Nursing
Trust Named Nurse Safeguarding Children - June 2013
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| 17th Dec| **Service Quality Improvement Committee Minutes from November**  
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