A MEETING OF THE BOARD OF DIRECTORS OF THE SOUTH LONDON AND MAUDSLEY NHS FOUNDATION TRUST
WILL BE HELD ON TUESDAY 27TH MAY 2014 AT
3:00pm BOARDROOM, MAUDSLEY HOSPITAL

AGENDA

1 APOLOGIES for absence: Nick Dawe

2 Declarations of Interest

3 Minutes of the Board Meeting held on 29th April 2014 Attached

4 MATTERS ARISING

   STRATEGY

5 To approve the Expanding Opportunities - Increasing Involvement Page 8 App A

   PERFORMANCE AND ACTIVITY

6 To discuss the Finance Report – Month 1 Page 36 App B

7 To receive the Summary Performance Report April 2014 Page 48 App C

   GOVERNANCE

8 To receive a Report from the Chief Executive Page 54 App D

9 To receive an Update from the Council of Governors Page 59 App E

10 To receive an Update on Kings Health Partners Page 62 App F

11 To receive verbal feedback following the Audit Committee’s consideration of SLaM’s 2013/14 Annual Report and Accounts, and Safe Staffing Report Page 63 App G

   INFORMATION

12 Director’s Reports Verbal

13 Forward Planners Page 64 App H

14 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 24th June – 12:00pm, Boardroom, 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.
MINUTES OF THE SEVENTY FIFTH MEETING OF THE BOARD OF DIRECTORS OF THE
SOUTH LONDON AND MAUDSLEY NHS FOUNDATION TRUST
HELD ON 29TH APRIL 2014

PRESENT

Madeliene Long Chair
Dr Martin Baggaley Medical Director
Dr Neil Brimblecombe Director of Nursing
Dr Patricia Connell-Julien Non Executive Director
Robert Coomber Non Executive Director
Nick Dawe Interim Chief Operating Officer
Harriet Hall Non Executive Director
Gus Heafield Chief Financial Officer
Kumar Jacob Non Executive Director
Prof Shitij Kapur Non Executive Director
Dr Matthew Patrick Chief Executive

IN ATTENDANCE

Mark Allen Service Director, Addictions CAG
Chris Anderson Council of Governors
Alison Baker PA to Chair & Non Executive Directors
Lucy Bubb Deloitte
Lucy Canning Service Director, Psychosis CAG
Bruce Clarke Clinical Director, CAMHS CAG
Sarah Crack Head of Communications
Eleanor Davies Service Director, B&DP CAG
Angela Flood Council of Governors
Mark Ganderton Council of Governors
Andy Glynn Council of Governors
Louise Hall Director of Human Resources
Roy Jaggon Head of Performance Management
Prof Sir Robert Lechler Executive Director King’s Health Partners (item 12)
Paul Mitchell Trust Board Secretary
David Norman Service Director, Older Adults CAG
Zoë Reed Director of Organisation and Community
Steven Thomas Audit Committee Secretary
Noel Urwin Council of Governors

APOLOGIES

Steve Davidson Service Director, MAP & Psychological Medicine
Jo Fletcher Service Director, CAMHS CAG

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.
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.

Dr Patricia Connell-Julien declared an interest as a former employee of King’s College London and as a Trustee of Southside Certitude Support.

MINUTES
The minutes of the meeting held on the 25th March 2014 were agreed as an accurate record of the meeting.

INTRODUCTIONS
Madeliene Long welcomed and introduced Sarah Crack as the new Head of Communications.

BOD 48/14 MATTERS ARISING

1) **Risk Management & Assurance Strategy – BOD 41/14**
   Gus Heafield explained that the RM&A Strategy would be brought back to the Board of Directors meeting in May 2014, once advice from Deloitte had been received.

2) **Board Committee Review – BOD 42/14**
   Paul Mitchell explained that the reporting arrangements regarding the Mental Health Act Committee to the Quality Committee had been clarified, and a meeting of the Quality Committee would be held in May. Dr Matthew Patrick commented that Deloitte had been invited to comment on the Terms of Reference.

BOD 49/14 SERVICE QUALITY INDICATOR REPORT
Nick Dawe explained that the auditors were conducting a data check around the Home Treatment Team target to ensure data accuracy, feedback had been received that the data collection had met their requirements, however this needed to be received formally.

Harriet Hall commented on the green indicators regarding patient safety, and asked whether this was due to the effective use of interventions. Dr Martin Baggaley explained it could be in part, however it was probably due mainly to the closure of the NDS unit. Eleanor Davies explained that the forensic service had gone through a radical overhaul and reconfiguration, which had been a huge credit to the hard work of the team pulling together and working with patients which may have contributed to the reduction in violence. Dr Neil Brimblecombe also explained that the use of aggregate data may also mask month to month variation, and suggested that in future the Quality committee should advise the Board regarding trends.

Nick Dawe explained that the absence of suitable housing was one significant cause for the delay of patient discharges. The longer term solution lay in the improving relationships with LAs, housing providers and CCGs through discussions around the transformation of Adult Mental Health services. Dr Martin Baggaley explained they were making every effort to keep delayed discharges to a minimum, with daily reviews of all relevant cases.
Dr Neil Brimblecombe explained that quality priorities for the year would be reported to the Board of Directors.

The Board of Directors noted the report.

**BOD 50/14 INFECTION CONTROL REPORT**

Dr Martin Baggaley explained that this report updated the Board of Directors of Infection Control data with particular reference to MRSA, C.Difficile and outbreaks.

It was agreed that this report would in future be included within the main Service Quality Indicator Report. **Action: Dr Martin Baggaley/Nick Dawe.**

The Board of Directors noted the report.

**BOD 51/14 FINANCE REPORT – MONTH 12**

Gus Heafield explained that the draft accounts had been submitted to Monitor and the External Auditor, this had been a challenging timescale as it had coincided with the submission of the plan which was brought forward from previous years. A meeting of the Audit Committee had been arranged for May to agree and sign off the final Audited Accounts.

The month 12 position ended £2.5m above forecast at £10.5m adverse from planned EBITDA, the movement from forecast was largely due to an increase in the provision against income due from CCGs. The underlying gap of £8m had been driven by the financial impact of an increase in acute/forensic bed activity and residential/complex placements outside the Trust. The cash position was favourable due to debtor payments and slippage on the capital programme. Dr Martin Baggaley reported that the private sector control mechanisms were working with a significant reduction in private sector overspill, only one authorisation having been made since they had been introduced. The current plan is to have no overspill by June.

Gus Heafield emphasised the importance of maintaining financial control during Q1 of 2014. Bob Coomber highlighted that not all commissioning risks had been transferred as some still remained with the Trust. The Board would need to know what action was being taken, as the timescale for reacting would be more pressing than in previous years. After the accounts were closed it would be useful to seek comparative data to enable informed decisions to be made.

Dr Martin Baggaley emphasised the importance of clinical engagement in order to improve quality and produce better value. He was undertaking a series of meetings with Medical Advisory Committees to ensure such senior staff engagement. He suggested that some interventions gave little additional value to patients and should be curtailed.

The Board of Directors noted the report.

**BOD 52/14 PERFORMANCE MANAGEMENT FRAMEWORK**

Nick Dawe explained that following a Performance Management Framework workshop it had been agreed to introduce this new report which would bring
together all aspects of the Trust’s performance and delivery into one report. It would blend quality and outcome, resource and infrastructure, programmes and projects and operational delivery together. This would allow a full drill down from Trust wide objectives and priorities to individual tasks and actions by service team. In addition to this performance pyramid approach there would be a stronger concentration on the pace of performance improvement and the comparative position of the Trust.

The Board of Directors noted the report.

BOD 53/14 STAFF SURVEY REPORT
Louise Hall explained that this report provided feedback on the NHS England Staff Survey results which the Trust had participated in each year since 2000. The 2013 survey comprised a sample of 850 employees of the workforce. The response rate to the survey was 309 which was a significant reduction on previous years. It was also in the lowest 20% of all Mental Health and Learning Disabilities Trusts in England.

A particular area of focus was the prevention of violence and aggression towards our staff and discrimination at work. It was agreed that further work was needed within this area in order to understand the underlying issues.

The Board of Directors noted the report.

BOD 54/14 CHIEF EXECUTIVE REPORT
Dr Matthew Patrick reported that Boris Johnson had launched Med City, a major new initiative backed by some of the country’s senior academics and business leaders that would transform the London-Oxford-Cambridge life sciences sector. The Trust would be represented in this new organisation through King’s Health Partners.

The CQC were planning a round of targeted inspections on services for people in mental health crisis. They had identified 161 places of safety in England but found more than a third did not accept young people under the age of 16. This was not the position at SLaM where we had a policy for supporting young people under 18 when they were taken to a POS.

The Board of Directors noted the report.

BOD 55/14 UPDATE FROM THE COUNCIL OF GOVERNORS
Angela Flood introduced the report and explained that the Annual plan meeting had been well attended, where they had received an overview of the two year Operational Plan and its link to the developing five year Strategic Plan, it was agreed that comments could be forward to Angela Flood, Chair of the group, to enable them to be collated and forwarded to Zoe Reed in time for the Strategic Plan to be taken to the Board of Directors June meeting.

The deadline for comments on the recently circulated paper “Expanding Opportunities – Increasing Involvement” had now been moved to 9th May.
Letters had been sent to all members regarding the Bids programme “Smile for Health” with the launch taking place on 8th April where information on the bid process had been made available.

The Board of Directors noted the report.

BOD 56/14 UPDATE ON KING’S HEALTH PARTNERS - VERBAL
Prof Sir Robert Lechler verbally updated on current KHP issues.

Outstanding issues regarding vascular surgery still needed to be resolved. A joint facilitated meeting of the two acute Trusts had been arranged which was designed to exchange views and resolve differences.

Bob Coomber asked whether the new governance structures helped to deal with the issues faced. Prof Lechler explained that the new governance structures were in place and were working well. The KHP Board chaired by Rick Trainor had met for the first time last week, which had been a positive meeting, where they had agreed to recruit additional NEDs.

The KHP Executive Board, chaired by Madeliene Long had met three times, and was functioning well. It was noted that the Chief Executives attend as lead executive for major programmes of work not as representatives of their Trust. Dr Matthew Patrick was leading on integrated care.

The Operational Executive led by Prof Lechler would meet fortnightly and would push for delivery.

Prof Lechler reported that the three AHSCs in London had met with Simon Stevens, the new Chief Executive of NHS England. The three AHSCs had also attended the launch of Med City, the initiative for developing the life sciences sector.

Prof Lechler reported that a joint four way Board meeting was being arranged before the end of summer. A visit was also being arranged for NEDs from all four Boards to visit Johns Hopkins in either September or October.

The KHP Annual Conference had been arranged for 18th June with invitations being sent out shortly.

The Board of Directors noted the verbal report.

BOD 57/14 AUDIT COMMITTEE MINUTES, SIGNED & SEALED REPORT & DRAFT REVISED TOR
Bob Coomber explained that the terms of reference had been updated and approved and no significant changes to the Audit Committees remit were considered necessary, only changes to reflect current nomenclature and to allow a duly selected representative from the Council of Governors to attend Audit Committee meetings.
Following the meeting held on the 25th March there were no matters requiring escalation for the attention of the Board, however it was noted there were outstanding issues around IT and Estates.

The Board of Directors noted the report.

BOD 58/14 DIRECTOR’S REPORTS

- Madeliene Long – reported that the third KHP Nursing and Midwifery Conference would be taking place on the 8th & 9th May. It was exciting to see how nursing had changed over the decade and it was good to share experiences. Chief Executives and senior managers had been encouraged to attend. Dr Neil Brimblecombe reported that they had been over prescribed from the SLaM nursing workforce.

Madeliene Long was also chartering the FTN NEDs Network Conference, where there would be an interesting group of speakers, this would enable other Chairs from Foundation Trusts to see the progress we had made.

BOD 59/14 FORWARD PLANNERS

The Forward planner was noted.

BOD 60/14 ANY OTHER BUSINESS

No other business was considered.

BOD 61/14 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 27th May 2014 – 3:00pm Maudsley Board room, Maudsley Hospital, Denmark Hill, London, SE5 8AZ

Chair
TRUST BOARD OF DIRECTORS – SUMMARY REPORT

Date of Board meeting: 27th May 2014
Name of Report: Expanding Opportunities – Increasing Involvement: improvements to patient and carer involvement structures and mechanisms
Heading: - (Strategy, Quality, Performance & Activity, Governance, Information) Strategy
Author/s: Ray Johannsen-Chapman, Alice Glover, Nuala Conlan, Susan Holton, Jim Ellis, Macius Kurowski and Zoë Reed with contributions from others working in this area
Approved by: Matthew Patrick
Presented by: Zoë Reed

Purpose of the report:

This report sets out two proposals to improve the effectiveness and reach of the Trust’s service user and carer involvement mechanisms and structures:

a) The establishment of a new forum [EPIC – Engaging Patients, Involving Carers] to provide Trust-wide strategic leadership and oversight of service user and carer involvement, and
b) Changes to the Involvement Register [IR] to increase equality of access to opportunities and to widen and increase the Involvement Register membership and activity.

The Trust has a long history of involvement of service users and carers at each level of its activities – Individual, Team, Directorate/CAG, and Trust wide. This report focuses on the Trust-wide level and makes a proposal to clarify and strengthen the accountability mechanisms. To provide context, however, a snapshot is included demonstrating the range of involvement activities which take place across the Trust.

The difference between service user and carer involvement and public involvement is a fine one. Service Users and Carers are also members of the Public and members of the Public are potentially our service users and carers. An example of the way the Trust is continuing to develop its reach in the public involvement area is the work undertaken by the Council of Governors as part of the Annual Forward Plan development process when they host events in each borough to which public, staff, service users and carers all attend and make their contribution. Nevertheless the primary focus of the new group is service users and carers - to share good practice and ensure full coverage of mechanisms and structures across the Trust. The Trust’s Involvement Strategy and Policy needs refreshing and bringing up to date and this will be a task for the new group.

A very small but important part of the Trust’s involvement activity is supported through the Involvement Register and its current operation has had some unintended consequences. This report seeks to regularise the situation by putting in place some rules about duration of contribution. Further development will be required and it is intended to establish an IR Management Group to review and put in place other controls and definitions to ensure fair
and equitable allocation of opportunities with the intention of increasing the numbers and diversity of active IR members.

The need to ensure the range of service users and carers actively involved matches the diversity of our local communities is another important task to be undertaken by the EPIC group and IR Management group.

Consultation took place during the autumn last year culminating in a formal feedback session in November. Following a presentation to the Council of Governors there was an extension of the consultation for further comments and feedback up to May 9th 2014. There has also been a series of reviews around the Involvement Register (including focus groups and feedback questionnaires in 2012). Additionally there was a series of focus groups and feedback sessions about how the PPI Strategy/Policy should be developed.

**Action required:**
The Board is asked to approve the recommendations.

**Recommendations to the Board:**
The Board is asked

To approve the creation of the Engaging Patients Involving Carers [EPIC] group with membership drawn from internal service user and carer groups and external borough based service user, carer and Healthwatch organisations together with appropriate staff. The creation of this group will provide clear line of sight from the CAG Service User Advisory Groups [SUAGs] to the Senior Management Team and the Trust Executive, linkage between CAG SUAGs and other internal and external bodies working on involvement and with the Council of Governors as well as increasing the accountability of all participants.

To approve the changes to the Involvement Register [IR] intended to increase the numbers of service users and carers undertaking involvement assignments through the IR, within the Trust, by restricting the number of hours that can be undertaken by any individual to 30 hours per month, introducing a two year review and encouraging staff commissioning involvement activities to put in place mechanisms locally that increase the flow of service users and carers through the IR.

To note that EPIC will produce an Annual Report to the Board with interim progress reports to the Senior Management Team and Trust Executive.

**Relationship with the Assurance Framework (Risks, Controls and Assurance) and level of assurance provided by the report - none, low, moderate, high:**
The provision of on-going feedback from service users and carers is a crucial aspect of providing assurance on the quality of clinical care. This report seeks to strengthen this component of the Trust’s assurance mechanisms.

**Summary of Financial and Legal Implications:**
The Trust spent in excess of £100,000 per year for the last 2 years on involvement assignments funded through the Involvement Register. These proposals will increase the equity of access to this resource and ensure it is spent more judiciously.

**Equality & Diversity and Public & Patient Involvement Implications:**
An EIA is being developed as part of this review and is identifying areas where there is a need to increase the involvement of groups within the 9 protected characteristics. This will be an important part of the work of EPIC and the IR Management Group going forward.

**Service Quality Implications:**

Service Quality is enhanced by the active involvement of service users and carers at every level of the Trust – Individual, Team, Directorate/CAG and Trust-wide. The proposals in this paper will strengthen the mechanisms and structures in this area.
Expanding Opportunities – Increasing Involvement: improvements to patient and carer involvement structures and mechanisms

Introduction

The requirement for genuine and meaningful patient and carer involvement in services is well established and understood. Within SLaM we have examined how best to develop this area, building on organisational strengths and addressing structural weaknesses. In this respect, two main strands have informed the proposals set out within this paper. The first of these, a review of the current structures and functions of the Trust-wide involvement groups, has identified the need for a single group to provide strategic leadership, oversight and accountability across the Trust. The review was informed by local patient, carer and staff input, as well as the 2011 NICE Service User Experience in Adult Mental Health report, and work undertaken to develop the report called An Organisational Response to the Francis Report, presented to the Board in February 2014. The second strand relates to the operation of the Involvement Register and aims to address perceived inequality in access to participation opportunities and in remuneration for participants.

This report sets out two proposals for change:

a) The establishment of a new forum (EPIC - Engaging Patients, Involving Carers) to provide Trust-wide strategic leadership and oversight of patient and carer involvement, and;

b) Changes to the Involvement Register to increase equality of access to opportunities and to widen and increase the Involvement Register membership and activity.

Background

The proposed changes will aim to retain current best practice employed within the Trust, increase the transparency of participation access routes and enhance strategic leadership. We hope that these changes will enable a more equitable and well-functioning structure from which to develop a working strategy/policy around Patient & Public Involvement that will support the Trust’s emerging 5-year Plan.

It is widely recognised, that healthcare providers need to engage with service users and not simply provide services to them. Increasingly, a more collaborative approach to developing services is used and SLaM offers opportunities for all stakeholders including members of the public and local organisations to get involved in shaping our services.

A snapshot review (see Appendix 1) of engagement across the Trust shows how SLaM staff actively engages with thousands of service users, carers and members of the public; seeking and listening to their opinions and ideas for improvements. These interactions happen routinely in community meetings on wards, one to one discussions with service users and carers themselves and Link Workers; Patient Experience Data Intelligence Centre (PEDIC) patient experience surveys; or more specifically in organised group discussions, focus groups and community events.

Additionally, there are a smaller number of more formal opportunities for involvement where people with lived experience help with recruiting staff, delivering training, participating in committees, running focus groups, assessing the quality of services or collaborating on service improvements. This aspect of formal involvement generated one of the issues this paper is seeking to address. A significant number of involvement activities were undertaken...
by a small number of people and, though no one's fault, overtime this led to feelings of inequality of opportunity.

**Issue 1)** Over time, whilst the number of people on the Involvement Register has grown, a relatively small number of people are actively engaged in these more formal opportunities.

Nationally, there is an increasing focus on transparent, equitable and productive PPI systems. Within SLaM, over the last 4 years new organisational management structures have been introduced and with that new local involvement mechanisms. The existing Trust-wide PPI structures needed to be reviewed in light of these changes.

**Issue 2)** Existing Trust-wide patient involvement structures lacked strong governance, accountability and the ownership of the senior leadership.

**The recommendations:**

1) **Addressing Issue 1:** To make the following changes to the Involvement Register and formal involvement opportunities:
   a. To limit the number of hours that any one individual can do to 30 hours per month
   b. To stop paying individuals for time spent when undertaking training
   c. To remove the lowest rate of pay (£7.10).
   d. Staff to review individuals involvement and on-going opportunities after 2 years
   e. To agree and implement a code of conduct for members of the involvement register
   f. To ensure that all members of the IR are also members of the Trust
   g. To set up a management group to oversee the running and further improvement of the involvement register.

2) **Addressing Issue 2:** To dissolve the existing Trust-wide involvement groups and to develop one new forum (EPIC - Engaging Patients, Involving Carers) that has a broader membership, clearer accountability and is inclusive for staff, CAG service users and carers and external partners.

Our aim is to guide and set standards of involvement to ensure consistency and shared purpose. The PPI team, PPI Leads and EPIC members will play an important role to make sure that everyone in SLaM considers patient experience to be their responsibility and will support and assist them to this end. This report sets out an approach that will provide appropriate governance and the assurance that the Trust is providing everyone with the chance to become formally and informally involved and engaged in a positive and safe environment.

**Our Vision, Aim and Objectives for Patient & Carer Involvement**

As the Trust develops its five-year Strategic Plan there is a crucial component, which is the commitment to working in partnership as a primary mode of operation. At the heart of this is working in partnership with service users, carers and our local communities. The Organising Framework for the Trust's Strategy is set out below.
The Strategy is founded on Peer Support and Self Management and it is clear from this that service user and carer involvement and its systematic application across the Trust is essential to our 5-year Plan. The Trust has an extensive history of involvement and is leading the way nationally, for example, in the field of peer support workers embedded in our teams. EPIC’s role will include supporting the Trust to identify and standardise good practice across all aspects of involvement in the Trust and ensure we remain at the cutting edge in this field.

The February 2014 report to the Board of Directors outlined how the Trust is responding to the Francis Report and identified a model for change that includes four essential elements to mitigate against the possibility of serious failures of care and compassion happening in our services. One of these four elements is ‘Working with service users in a spirit of co-creation and co-production’, and states ‘Increasingly over recent years mental health services have acknowledged the importance of working collaboratively with service users as individuals and groups. This ideal has been enforced by successive national mental health strategies. The Francis report recommends strong collaboration as a key defence against poor patient experience, and the development of damaging cultures’. That report identified an action plan for the organisation. EPIC will be involved in setting standards, agreeing targets, driving and governing co-produced projects.

Our vision requires us to listen to and involve patients and carers so we can understand how we can best serve their needs as individuals and fulfill our commitments to collaboration in partnership. The aim is to ensure that the Trust will continue to involve and engage with patients and carers from all backgrounds in a meaningful way to help deliver, develop and improve our services. We will strengthen our existing systems so that patient and carer
opinion is listened to, informs us and is part of a two way improvement process comprehensively across the Trust.

To achieve the Trust’s objectives, SLaM needs to ensure that involvement is as inclusive as possible. We have an active caseload of 37,000 patients and although some people will not wish to be involved, our involvement aspirations should be to continually expand opportunities to capture the opinions and views of the diversity of service users and carers we serve. The Francis Report drew attention to the fact that ‘patient involvement structures relied on goodwill and insight to make them work – in Staffordshire this meant they broke down’. To prevent this, these involvement objectives must be founded in best practice, which is systematically:

- To involve patients and carers in planning, developing and where practicable delivering accessible health services and to improve the quality of care.
- To promote patient and carer involvement, in partnership with health care professionals.
- To ensure accessibility to good quality patient and carer information
- To support patients and carers to develop their knowledge and skills so that they can contribute to service policy development and planning
- To promote active participation between the Trust and other statutory agencies and voluntary organisations
- To support staff to develop their awareness and understanding so they can continue to contribute to involvement
- To ensure effective monitoring and evaluation of involvement processes and structures
- To ensure that patient experience and involvement is the responsibility of all staff

SLaM’s commitment to involvement and patient engagement means that it is always keen to make improvements. The Trust Patient and Public Involvement Team and the CAG Patient and Public Involvement Leads have prepared this paper with support from Human Resources, following Involvement Register reviews with members and feedback from service users and carers. Naturally, this process brings out different and sometimes conflicting views and therefore not all have been accommodated. It aims to describe:

- The current Trust Wide Patient and Carer involvement structures
- The mechanisms for making payments via the Involvement Register
- Proposals to address the issues

**Current Trust-wide Patient Involvement Structures in SLaM**

Within the Trust, there are currently a number of groups, which are responsible for the implementation and management of involvement activities. This report is only concerned with groups that operate at a Trust-wide level. The three key Trust wide groups relating to involvement and improving patient experience operating across SLaM:

1. **The Patient Experience Group (PEG)**: Chaired by Dr Martin Baggaley, PEG was initially set up to explore how the Trust could improve its scores on the National Patient Survey and internal Patient Experience (PEDIC) surveys, and patient experience CQUINs. It operated as a stand-alone group.
2. **Trust Wide Involvement Group (TWIG) Strategic**: This group was chaired by an elected service user and co-chaired by the PPI Lead. The aim of TWIG Strategic was to oversee the development of involvement within SLaM. Membership of the group included service users who were originally selected as representatives from other service users groups, internally and externally. The group operated as a challenging critical friend, holding the Trust to account over a number of PPI issues. The fluid membership of TWIG and the lack of structural governance within the Trust often left the group limited in its’ reporting objectives.

3. **Trust wide Involvement Group (TWIG) – Operations**: An elected service user and PPI Lead also chaired this group. The aim of TWIG Ops was to be involved on service improvement issues identified by staff and service users. The aim was to follow a co-productive model, to work in partnership with staff to improve services in the Trust. Some of the projects that the group developed were very successful, others less so. This again, was due to the limitation around reporting objectives. Secondly, the lack of strategic governance meant that the TWIG Ops membership became limited.

**Why Review the Existing Patient Involvement Structure in the Trust:**
The key messages from our reviews and from a number of national reports (some cited above) indicates that SLaM needs:

1. To widen participation;
2. To challenge the culture of patient experience so it becomes everyone’s responsibility,
3. To improve accountability and linkage between patient involvement structures and other governance structures within the Trust, and
4. To ensure transparency in allocation of opportunities and remuneration for participation.

**Proposals:**
To introduce a new ‘flatter’ trust-wide group that is chaired by the Director of Organisation and Community. This new body will be called the Engaging Patients Involving Carers (EPIC) Group, replacing existing trust wide groups (PEG, TWIG Ops, and TWIG Strategic). The new group will meet bi-monthly and have five main functions:

1. To ensure that all patient experience data, information and involvement activities are brought together and assessed
2. To understand SLaM patient experience data (from surveys and focus groups) and communicate findings and recommendations
3. To develop and maintain the patient experience and involvement policy that ensures consistency across the Trust
4. To support, advise and evaluate all trust wide patient experience priority projects for CQUINs and service improvements
5. To formally report to the Senior Management Team and the Trust Executive.

This new approach will bring the following benefits:

- A consistency of style, approach and philosophy to service user and carer involvement throughout the Trust
- Provide strategic coordination and drive
• Provide an effective method of reporting to Trust Senior Management and the Executive
• Provide fair and robust structures for all PE activities
• Promote and support each CAG’s SUAG
• Provide professional and supportive governance
• Ensure that the Trust takes responsibility for the task of organising meetings rather than it falling to individual carers or service users.
• EPIC will strive to be representative and accountable through its engagement with appropriate stakeholder groups and organisations to widen participation and communication, accountability and transparency.
• We will endeavour to ensure that the succession of individuals participating in EPIC reflect SLAM’s varied populations.

The Involvement Register

A description of the Involvement Register

The Involvement Register (IR) was set up in 2007 in response to Rewards & Recognition 2006 Guide. At this time, it was felt that people should receive a financial reward for their contribution to specific work streams. The IR is also seen as a stepping-stone towards paid employment as part of service users’ recovery journey.

The IR provides payment in recognition for an individual’s input - experience or expertise - or tasks undertaken e.g. gathering the views of others. The payment is for ad hoc activities and is not intended as formal employment. There are three payment rates: £7.10, £10 and £15 per hour. The rate depends on the complexity of the activity.

In 2012, and 2013, the Trust made payments of over £100,000 to individuals through the IR, the 2014 figure will be over £100k, running at £9k to £10k per month. The number of people joining the IR significantly increased since its inception however it has not been comprehensively reviewed.

Currently, there are around 240 people signed up to the IR, which is only a small proportion of the active patients and carers that we work with. Since June 2013, the number undertaking activities through the IR has risen from 52 to 68; this positive increase still means that over 170 members on the IR are not doing any involvement activities. The aim therefore, is to ensure that the opportunities presented and monies available go to a wider group of people. The financial climate is challenging across the NHS however the proposed IR changes are not financially driven.

Table 1 below shows that there are only a small number of individuals who regularly go over 30 hours per month; the aim of the recommendations is to be clear with IR members from the outset what the boundaries are and to encourage more and more service users and carers to undertake involvement assignments. A number of changes are proposed to ensure that the IR involves a widening group of service users and carers who currently and recently receive services within the Trust. In this way, the Trust benefits from very current feedback.
Table 1: Involvement Register activity over past 9 months

<table>
<thead>
<tr>
<th>Month</th>
<th>Number of members undertaking activities</th>
<th>Number of accumulated hours</th>
<th>Number of people over 30 hours</th>
<th>Number of accumulated hours</th>
</tr>
</thead>
<tbody>
<tr>
<td>June 2013</td>
<td>52</td>
<td>716</td>
<td>4</td>
<td>206</td>
</tr>
<tr>
<td>July 2013</td>
<td>59</td>
<td>894</td>
<td>5</td>
<td>367</td>
</tr>
<tr>
<td>Aug 2013</td>
<td>55</td>
<td>667</td>
<td>4</td>
<td>213</td>
</tr>
<tr>
<td>Sept 2013</td>
<td>55</td>
<td>660</td>
<td>4</td>
<td>277</td>
</tr>
<tr>
<td>Oct 2013</td>
<td>62</td>
<td>722</td>
<td>6</td>
<td>210</td>
</tr>
<tr>
<td>Nov 2013</td>
<td>61</td>
<td>777</td>
<td>5</td>
<td>175</td>
</tr>
<tr>
<td>Dec 2013</td>
<td>56</td>
<td>645</td>
<td>3</td>
<td>108</td>
</tr>
<tr>
<td>Jan 2014</td>
<td>59</td>
<td>635</td>
<td>6</td>
<td>200</td>
</tr>
<tr>
<td>Feb 2014</td>
<td>68</td>
<td>790</td>
<td>6</td>
<td>230</td>
</tr>
</tbody>
</table>

Proposals:
1. The process of joining the Involvement Register

Firstly, before discussing any changes it is important to outline two contentious areas that will remain and why. The requirement to go through the Occupational Health Assessments will not change, as this ensures that people are offered appropriate opportunities and support where needed. The process of undertaking a CRB now known as the Disclosure & Barring Service (DBS) checks will also continue.

Everyone on the Involvement Register and joining the Involvement Register will be issued with the Code of Conduct and a role description and timescale for any assignment they undertake. This provides both staff and members of the IR with a clear understanding of their expectations and where and when the activity starts and ends.

The role of the sponsor/referee, who act as a character reference for anyone joining the IR will change. The sponsor/referee’s role will be made more explicit, particularly the expectation that they remain in contact with the service user/carer during the assignment and provide a source of contact for the IR Management group. The IR Management group will also work more closely with vocational and volunteering services to provide a wider range of opportunities for IR members. Another proposal from the Governors is that everyone on the Involvement Register should also be a Member of the Trust, and this will be built into the sign up mechanism.

2. Opportunities that can be paid for

Individuals on the IR will continue to receive payment where a specific outcome or contribution is made e.g.:

a. Delivering training
b. Contributing to meetings
c. Facilitating focus groups
d. Undertaking audits, service reviews, evaluations and/or surveys
e. Taking part in recruitment panels
3. Allocation of Opportunities

In order to encourage wider participation from IR members and increased flow through the system the following alterations will be introduced:

- The total number of hours an individual can claim through the IR will be 30 hours a month.
- There will be a 2-year review period, which will start when a new member undertakes their first activity. Before the end of this two-year period they will be invited to a review meeting to include the IR management and their sponsor/referee. The purpose of the review meeting is for the sponsor/referee and the individual to explore other opportunities along their recovery journey.
- There will be considerations made for the CAMHs, BDP and MHOAD CAGs. Firstly, there are fewer clients from these CAGs who are involved and secondly it often takes longer for some of these clients to be trained.
- PPI Leads and staff commissioning from the IR will be asked to demonstrate greater flow through the IR. This will mean that commissioning staff will have to think about fairness and equality of access. We all have a duty to seek new/more service users and carers who might make a contribution to and benefit from membership of the IR as well as helping those who have been active for two years to consider ways of moving forward in their recovery journey and off the IR.

4. Payment

Two rates of payment will be introduced. A flat rate payment of £10 an hour will be introduced for all people aged 16 and above. Children under the age of 16 years of age will be rewarded with a £10 gift voucher. The higher rate of £15 per hour will remain but for the more complex activities. A strict set of criteria will be developed to ensure that this higher pay band is used appropriately.

For a very small number of people these restrictions will represent a reduction in hours of paid involvement activities. In order to help people plan for this change there will be a notice period of 3 months so that people can make necessary adjustments. Following this period, the IR Management group will determine which activities are involvement opportunities and those activities that best sit elsewhere e.g. volunteering or employment. However most people will not be affected, as for the majority of members this change will work positively by increasing their opportunity for involvement through the IR. For a variety of reasons, some IR members do not wish to take any payment from the IR and this will continue to be accommodated.

The Concerns

An event was held in November 2013 to outline the above proposals. The event was well supported with over 60 people attending. Feedback was received at the event and from a range of sources before and since. A number of Service User Advisory Groups (SUAGs)
(Psych Med, MAP, MHOAD and Psychosis) discussed the draft proposals. There was a joint-SUAG meeting, which provided challenging and important feedback about the proposals. There have also been discussions with Healthwatch Lambeth & Southwark, the Southwark User Council and Croydon Hear-Us. The Central PPI Team and the CAG PPI Leads wish to thank all individuals who not only attended organised meetings but also provided feedback through emails, telephone and letters.

Overall, there has been overwhelming support for the proposals to create the new Patient and Carer Involvement governance structure (figure 1). The Healthwatch organisations from the four boroughs are very keen to send representatives, as are Lambeth and Southwark Mind and Hear-us from Croydon. The idea of a Chair from the Senior Management and direct reporting to the Trust Executive was seen as a very important step forward. The Council of Governors has expressed an interest in representation onto the new body. There was some concern expressed about the size of the group and the perception that the Trust would have more control about the actions and direction for patient experience. Overall, the support for the development for this new forum is very encouraging.

The biggest concerns were around the proposed changes to the Involvement Register. The reduction of hours to 30 per month and the 2-year limit caused most concerns. However, there are only a limited number of individuals receiving payment for over 30 hours per month (7 individuals) in the last 6 months. Interestingly, since the event in November the number of people being involved has grown to 68.

The other outstanding concern was the 2-year limit. The original proposal was to remove individuals from the IR after 2 years. Following the event and further feedback the 2-year limit proposal now reads. "There will be a 2-year review period, which will start when a new member undertakes their first activity; just prior to two years from that date, they will be invited to a review meeting, to include IR management and their sponsor/referee. The purpose is to explore development including other opportunities along their recovery journey." It is important to stress that the purpose of the Review is to ensure that opportunities are spread much more fairly throughout the membership however each individual case will be discussed on its merit.

Further Feedback

The proposals were presented to the Council of Governors and it was decided that a further period of consultation take place and that the Board would consider the recommendations. A paper was circulated widely for a further 6 weeks.

The paper was circulated under cover of a letter, which acknowledged that many people had make contributions on the plans to expand opportunities and increase involvement for service users and carers. Specifically views had been offered at the November 2013 event and at other meetings and discussions and these had informed the changes to the proposals contained in the paper circulated.

Recipients of the paper were invited to consider that the final proposals contained in the paper had responded to the issues and concerns raised and given an email address to send any further points by the 9th May 2014 with an undertaking to take them into consideration when preparing the Board Report. A number of helpful suggestions were received and this paper was revised in the light of them including from an informal meeting with some members of the Council of Governors that had responded to the letter and report. The comments were primarily about the need to provide more detail and clarification of the proposals and how they would be implemented.
Recommendations & Timetable for actions

The proposals aim also to take account of the Francis Report. For example, the IR changes will enable a wider number of service users and carers to become more involved in the more formal aspects of involvement. The new Patient and Carer Involvement Governance structure will enable the Trust to be more open and transparent by working more directly and formally with our patients, carers and partners, whilst reporting patient experience directly to the Trust’s Senior Management Team and the Trust Executive. Table 2 and 3 below, highlights responses to some of the concerns raised throughout the consultation period.

Table 2
Involvement Register: Proposals, Feedback and Recommendations

<table>
<thead>
<tr>
<th>Original Proposals</th>
<th>Feedback</th>
<th>Recommendations</th>
</tr>
</thead>
<tbody>
<tr>
<td>3 pay rates to be reduced to 1 pay rate of £10</td>
<td>Some activities more complex</td>
<td>Maintain 2 rates of £10 &amp; £15 per hour</td>
</tr>
<tr>
<td>2 year review for all members</td>
<td>Fear that members would be asked to leave the IR after 2 years</td>
<td>Each case to be taken on its merit at review. Staff will aim to share activities fairly</td>
</tr>
<tr>
<td>2 year review for all members</td>
<td>Concerns that the expertise &amp; experience would be lost</td>
<td>Provide training for those with less experience – IR members could provide coaching</td>
</tr>
<tr>
<td>Limit up to 30 hours of activities per month</td>
<td>Some members unhappy about this proposal</td>
<td>The proposal remains to increase wider participation and fairness of opportunities</td>
</tr>
<tr>
<td>Limit up to 30 hours of activities per month</td>
<td>Would members be restricted to the 30 hours if commissioned by external bodies through the IR?</td>
<td>Yes they would but no member undertaking any external activity has ever gone over 30 hours</td>
</tr>
<tr>
<td>Limit up to 30 hours of activities per month</td>
<td>Would the rates of pay by external bodies be affected?</td>
<td>No change to any pay rates – the pay rates remain at £10 per hour</td>
</tr>
<tr>
<td>Commissioning staff to ensure fairer flow of activities for IR members</td>
<td>What if there is a lack of skill to undertake particular roles?</td>
<td>We know that there is a range of clients with wide-ranging skills. The task for the Trust is to ensure that we continually find more people with the required skills</td>
</tr>
<tr>
<td>Identify demarcation lines between volunteering and involvement activities</td>
<td>No concerns</td>
<td></td>
</tr>
<tr>
<td>Development of IR management group</td>
<td>Would IR members be elected to participate</td>
<td>Service user and carer will be approached to sit on the IR management group</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Funding and future development for the IR will be planned within</td>
</tr>
</tbody>
</table>
Why do new members have to go through Occupational Health? Some members felt this was demeaning and slows the application process. Occupational Health will remain. It provides the patient with good guidance about their well-being and provides the Trust with safety assurance.

Why do new members have to have a CRB? This potentially discriminates against ex-offenders. DBS (or CRB) will remain. It protects the service users, carers and the Trust against risk. There are a number of active ex-offenders on the IR.

Closer working relationship between IR activities, volunteering and vocational services. No concerns. To be assessed through the IR Management group.

Concern about the pressure on staff whose roles it may not be to provide support such as supervision. There needs to be a clear structure where service users on the Involvement Register can get the support they need. The role of the sponsor/referee will be expected to provide support.

A designated manager to manage the IR. The IR Management Group to review.

Table 3: Patient and Carer Involvement Structure: Proposals, Feedback and Recommendations

<table>
<thead>
<tr>
<th>Proposals</th>
<th>Feedback</th>
<th>Recommendations</th>
</tr>
</thead>
<tbody>
<tr>
<td>To dissolve the 3 PPI Trust-wide groups into one</td>
<td>Supported – questions how would membership be defined?</td>
<td>All members would be from designated groups and accountable back to them</td>
</tr>
<tr>
<td>To ensure governance pathway from SUs and Carers to Senior Management Team and the Trust Executive</td>
<td>Highly supported</td>
<td></td>
</tr>
<tr>
<td>Chair ed by Director of Organisation and Community to eliminate concerns about favouritism and elitism</td>
<td>Supported; minority concern about SU or Carer not being chair</td>
<td>Director of Organisation and Community to chair EPIC to eliminate concerns about favouritism and elitism and ensure connection to senior management of the Trust</td>
</tr>
<tr>
<td>---</td>
<td>---</td>
<td>---</td>
</tr>
<tr>
<td>In any new Trust-wide structure there is a need to maintain existing positive structures and relationships that operate in the CAGs</td>
<td>The existing patient experience structures in the CAGs will remain and be enhanced by representation on the new EPIC body</td>
<td></td>
</tr>
<tr>
<td>Concerns raised about the number of people attending may make it difficult to manage</td>
<td>In view of the size, the meeting will operate differently to traditional formal meetings to ensure full participation of attendees.</td>
<td></td>
</tr>
<tr>
<td>Suggestions about the name change and not to call it PEG as connected with previous patient experience group</td>
<td>The name of the new body/forum will be Engaging Patients Involving Carers (EPIC)</td>
<td></td>
</tr>
<tr>
<td>Advantageous to pilot the new group to assess whether the new structure works</td>
<td>EPIC will be assessed after one year</td>
<td></td>
</tr>
<tr>
<td>How will new service users and carers get the opportunity to be selected onto EPIC or onto the IR?</td>
<td>The 2-year review will provide greater opportunities for new patients and carers to be involved. The promotion and support for all services to develop their own patient experience group would enhance the flow-through for new members</td>
<td></td>
</tr>
<tr>
<td>Will the new forum help to develop a new PPI policy?</td>
<td>Part of the work-plan for EPIC will be to collaboratively develop SLaM’s Involvement Policy.</td>
<td></td>
</tr>
<tr>
<td>Will EPIC explore the steps for a PPI structural review across the Trust?</td>
<td>One of the overall aims of EPIC is to develop Trust-wide consistency and therefore this point will be considered</td>
<td></td>
</tr>
<tr>
<td>What is the definition of Patient Experience and Involvement from the Trust perspective? It would be helpful to have a statement set by patients, public, staff, volunteers and other parties as part of the new process.</td>
<td>As above, the role of EPIC is to work in partnership to develop Trust PPI Policy – will include work on definition</td>
<td></td>
</tr>
<tr>
<td>Question</td>
<td>Answer</td>
<td></td>
</tr>
<tr>
<td>-------------------------------------------------------------------------</td>
<td>--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------</td>
<td></td>
</tr>
<tr>
<td>The Trust has given a definition of Patient Involvement and Patient Experience can service users and carers produce a definition or use the NICE standard definition</td>
<td>One of the main functions of EPIC will be to develop consistency of engagement throughout the Trust.</td>
<td></td>
</tr>
<tr>
<td>The document set out the four functions of the PPI New Forum it focuses on internal activities. Who will have the role to oversee and coordinate external engagement/involvement activities to ensure consistency on principles and process?</td>
<td>The involvement of young people has often proved problematic. CAMHs are invited to sit on EPIC. The proposed roundtables style will mean that young people can participate. Further options to be considered.</td>
<td></td>
</tr>
<tr>
<td>We are particularly keen that children and young people have their views heard and strongly advise that user-friendly PPI structures are strengthened or implanted to ensure this</td>
<td>People attending EPIC from groups/organisations will be expected to feedback and be accountable to their group/organisation. The Trust will ensure that EPIC information is circulated in good time. There is an expectation of two-way flow of information.</td>
<td></td>
</tr>
<tr>
<td>How will the representatives get feedback and be accountable to their constituents? What support from the Trust will be in place to help them to do this?</td>
<td>Why has there not been a review of the CAG PPI structures at the same time?</td>
<td></td>
</tr>
<tr>
<td>It was proposed that the new PPI structure would be reviewed in a year’s time, how would this be</td>
<td>The CAG PPI structure is fairly young and developing – limiting the number of IR hours will automatically require CAGs to use greater numbers of services users and carers. EPIC will inevitably develop greater consistency for membership and patient experience across the Trust.</td>
<td></td>
</tr>
<tr>
<td></td>
<td>There is no decision as yet how EPIC will be reviewed. Success of the collaboration will determine the future of</td>
<td></td>
</tr>
</tbody>
</table>
conducted? What indicator and benchmarking will be used and how will it be decided? EPIC and any ideas for review can be determined by EPIC

In terms of communications, will the new structure minutes/notes be uploaded onto the Trust website? Suggestion – a new web platform for the new structure and CAG Service User Feedback

To be explored this is a useful idea

The PPI Strategy is referred to in paper however there is no mention on the intention to produce or publish a Trust wide PPI policy Strategy

The Trust will ensure that all PPI strategies, frameworks and policy are linked onto the SLaM website. EPIC will work collaboratively to develop a refreshed PPI policy

What staff and other resources across the Trust are available for PPI now and in the near future? Will any changes be made to reflect any of the changes?

This is another one of the reasons for the development of EPIC to generate a greater understanding of patient experience need.

To adopt the NSUN guidelines for service user involvement

EPIC would definitely make use of the NSUN guidelines alongside a number of recommendations

Itemised budget for service user activity

To be explored this is a useful idea.

A number of points requiring clarification were raised through this second consultation. One issue was the issue of the Trust’s Service User and Carer Involvement Policy/Strategy. The current Trust Policy is in need of updating and this would be a piece of work undertaken by EPIC. Another issue was the need for clarity on how the EPIC would operate and what its work programme would be – this is addressed in the section below.

The discussion generated by the report also indicated a need to emphasise the range of service user and carer involvement across the Trust - Appendix 1 contains a brief summary. This will be further described and discussed to spread learning and good practice as part of EPIC’s future work programme.

The EPIC work programme

EPIC will be organised in a way that maximises participation in its operation. This means giving careful thought to the work programme and how it is constructed and agreed. EPIC and its constituent organisations will be asked to consider what topics EPIC should consider and this will include suggestions from for example SUAGs, Healthwatch and the Trust Senior Management Team and the Trust Executive. The meetings themselves will need careful
organisation as the membership is large, to ensure that everyone is able to participate. Meetings will be organised in roundtable format with topics planned and discussion structured so that everyone’s point of view can be heard and considered.

The intention will be to create an environment within EPIC such that all members feel able to contribute and collaborate in driving forward improvements and the development of standards. The aim will be to ensure that as many service users and carers as possible are actively involved in helping the Trust. As the work programme for EPIC develops it is hoped that an open ‘Partnership Time’ approach can be adopted whereby meetings are open and welcoming to all who wish to work constructively in helping the Trust take forward this important agenda.

The feedback to this report has already generated a number of Topics, which include:
- Update the Trust Service User and Carer Involvement Strategy
- Building the map of Service User and Carer involvement across the Trust
- Sharing good practice of involvement
- Service user and carer communication in the Trust including social media
- How the EPIC structure connects to Community Health Teams and the Inpatient wards
- How young adults will be included into EPIC and its activities.
- How EPIC will connect and relate to organisations.

The Implementation Plan: The Patient and Carer Governance Structure (EPIC) and the Involvement Register:

<table>
<thead>
<tr>
<th>What</th>
<th>When</th>
<th>Who</th>
</tr>
</thead>
<tbody>
<tr>
<td>Report sent to all participants at the November event including the SUAGs, the IR members; also sent to borough based service user and carer organisations and Healthwatch/s and staff who commission through the IR. Paul Mitchell circulated to Council of Governors and convened an informal meeting as requested by Governors who responded to the consultation paper</td>
<td>Week beginning 24th March 2014</td>
<td>PPI Team and Paul Mitchell</td>
</tr>
<tr>
<td>Equality Impact Assessment</td>
<td>On-going live assessment</td>
<td>PPI Team, Equalities Manager, PPI Leads, HR &amp; appropriate others</td>
</tr>
<tr>
<td>Letters to be sent to Involvement Register Members notifying them of agreed changes [subject to approval at Board on 27th May 2014]</td>
<td>Week beginning 2nd June 2014</td>
<td>PPI Team, PPI Leads &amp; HR</td>
</tr>
</tbody>
</table>
The proposals to be implemented subject to Board approval

<table>
<thead>
<tr>
<th>Event Description</th>
<th>Date</th>
<th>Responsible Parties</th>
</tr>
</thead>
<tbody>
<tr>
<td>Development of IR Management Group: Looking at 2-year review, referee/sponsor role, code of conduct, definitions of assignments and projects, volunteering, involvement &amp; non-involvement activities etc</td>
<td>Week beginning 2nd June 2014</td>
<td>PPI Staff, HR &amp; IR members</td>
</tr>
<tr>
<td>Initial EPIC members to be formally invited</td>
<td>Week beginning 2nd June 2014</td>
<td>Director of Organisation and Community</td>
</tr>
<tr>
<td>First EPIC meeting: followed bi-monthly</td>
<td>Date to be consulted on</td>
<td>PPI team</td>
</tr>
<tr>
<td>Email staff who commission through the IR</td>
<td>Week beginning 2nd June 2014</td>
<td>PPI team</td>
</tr>
</tbody>
</table>

**Recommendations to the Board of Directors**

To approve the creation of the Engaging Patients Involving Carers [EPIC] group comprising representation from internal service user and carer groups and external borough based service user, carer and Healthwatch organisations together with appropriate staff. The creation of this group will provide clear line of sight from the CAG Service User Advisory Groups [SUAGs] to the Senior Management Team and Trust Executive, linkage between CAG SUAGs and other internal and external bodies undertaking involvement and with the Council of Governors as well as increasing the accountability of all participants.

To approve the changes to the Involvement Register [IR] intended to increase the numbers of service users and carers undertaking involvement assignments within the Trust by restricting the number of hours that can be undertaken by any individual to 30 hours per month, introducing a two year review and encouraging staff commissioning involvement activities to put in place mechanisms locally that increase the flow of service users and carers through the IR.

To note that an Annual Report will be made to the Board as well as interim progress reports to the Senior Management Team and Trust Executive.
Figure 1: Internal Patient & Carer Involvement Governance Structure

<table>
<thead>
<tr>
<th>Staff</th>
<th>CAG SUAG Reps Including Link Workers</th>
<th>Council of Governors Reps</th>
<th>Healthwatch Reps</th>
<th>4 Borough Based SU &amp; Carer Organisation Reps</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Other Internal SU and Carer Groups e.g. Psychology, Carer Group</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Engaging Patients Involving Carers</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>EPIC</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>The Senior Management Team (SMT) and Trust Executive</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Staff**
- All CAG PPI Leads 6 [covering service users and carers];
- OT rep X 1;
- Psychology rep x 1;
- Nursing rep x 1;
- Medical rep x 1
- Clinical Governance x1
- Equalities rep x 1
- Others as necessary depending on topic under discussion

**Service User/Carer**
- Council of Governors Rep x2 able to contribute to service user and carer involvement agenda
- 1 Rep from all CAG SUAGs x7

**External**
- Healthwatch x 4
- Borough service user and carer organisations x 4;
Appendix 1
Snapshot of involvement/engagement activity in the Trust

Set out below is some examples of patient and carer involvement activities. The aim of EPIC will be to standardise the excellent practice across all Trust services.

Service and CAG level user involvement

This aspect is thriving within certain parts of the Trust. Service users are being engaged with, listened to, consulted and responded to in a multitude of ways by committed and experienced user-focused staff on a day-to-day basis.

Service users opinions are actively sought through the PEDIC surveys and thousands are submitted and acted upon annually. Service users have also been involved in discussions on a variety of issues, such as; how they experience reception areas and discharge from community to primary care, feeling safe on the wards to name but a few. Fora for carers, service users, focus groups, community meetings, planning meetings, reflective groups, steering groups, patient stories and more, all help us understand the patient experience on an on-going and routine basis.

The Care Pathways were developed through involvement of service users, carers and voluntary organisations, whilst the CAG’s Service User Advisory Groups have become particularly important and active mechanism for CAGs to engage with service users in ways best suited to them. Each one has developed differently, reflecting the CAGs’ needs, yet all are equally important and useful. Each, in time will develop appropriate ways to ensure the patient experience and voice from their CAG is heard within the new governance structure and is supported and guided by that mechanism appropriately.

It is also important to note that Protected Therapeutic Engagement Time (PTET) now routinely happens on inpatient wards and is closely monitored. This daily one-to-one time is for staff and service users to discuss their own individual needs. All this activity ensures that SLaM listens to and understands the patient experience and involves them in their own care. The PPI Team, PPI Leads and the new governance structures will ensure the right support, assistance and guidance is there to promote this activity to ensure it continues to happen, happens everywhere and continues to happen to a high standard.

- PALS – Patient Advisory and Liaison Service

Around 4,000 contacts are made with the PALS team annually. These contacts are made by service users, neighbours, carers, friends and relatives, GPs, the voluntary sector, private referrals, the public, other NHS Trusts, government agencies, private companies, legal agencies, staff and from people who wish to remain anonymous to us. Because of SLaM’s national and international reputation, these contacts come from across the UK and internationally. The PALS team deals with a wide variety and diverse range of issues.

Over half of all the PALS contacts received are information requests. Whilst not clinically trained the team have strong links with people who are and offer information on an extensive range of mental health conditions to enquirers. The team also directs people wanting access to IAPT services and to other services provided by the Trust. PALS also deal with crisis calls (people in crisis themselves or alerting the Trust to those that are), and contacts from service users / carers/ GPs wanting referral information; ‘switchboard’ and Data Protection type calls, and companies and others wanting our infrastructure departments i.e. finance as well as obviously concerns and complaints.
The PALS provide a valuable service to the people who contact them and to the Trust. Through listening and engaging with those who make contact, it provides the organisation with extremely important information that when used with other data and information sources gives an insight into the patient experience.

- **Engaging Black Communities**

The Mental Health Promotion Team undertakes a number of activities specifically geared to engaging with black communities service users and carers, for example

**Does spiritualising mental illness help or hinder?**

This conference was aimed at engaging faith communities. It was attended by faith leaders’ pastors, ministers, Imams, and reverends from diverse faith communities including Muslim, black majority churches, Sikh, Quaker, Rasta and Catholic, as well as a large number of SLaM staff from various levels, service users, young people, parents, elders and community groups including those who had physical disabilities.

The conference gave a platform for the community to be informed and to have a voice using a range of methods including interactive role play that enabled emotional and psychological engagement with the issue of mental health. Challenging topics explored during the conference included: who to trust, sibling conflict and carers responsibility, stigma of using mental health services, fear of being misunderstood, fear of losing rights, freedom, mistreatment, forced medication and inconsistency, the challenge of caring at home, increased anxiety and responsibility; keeping away from mental health services, the tension of being diagnosed and self-medicating, living with mental illness and watching your family hurt by it, and the trauma and cause of the mental illness.

This was balanced with provision of information on how to access services, professional expertise and information, workshops, a Q&A session, and a panel discussion on ‘is spirituality and faith more effective than psychiatry or vice versa?’ Meanwhile the young people ran a workshop on understanding mental health from a youth perspective with adults who wanted to hear their story. Out of this workshop came the call for youth to have more time. What made this event so special is that the faith community owned it. The conference attracted over a 150 people between 2pm and 8pm 13th March 2013 on the Old Kent Road.

**Belief kill & belief cure – Youth Wellbeing Conference**

This conference was co-produced with the communities by enabling them to offer contributions, shape the conference, run workshops, promote and present. We sought to have real understanding of what the issues are for young people and how to engage. We also had to work with the fear organisations had about not understanding mental health and young people.

The excellent range of young people focused workshops that ran covered: what does identity have to do with wellbeing; me and my body; tell it like it is; how to relax; how to talk about mental health; drugs awareness and mental health; and body maintenance. There were stalls from specialised projects that enabled concerns to be shared and to provide information to help understand diagnosis and what to do, with information on the innovative Wellbeing Website developments and art displaying positive self-image and contributions to society. Experts informing the community of how to recognise anger and depression and the types of treatment available complimented this. Young people sang songs that moved the soul and there were presentations from young people from a school we have worked with on raising self-esteem in young black boys. In addition, a young person by the name of Asherine Weston-Frost produced a short film called Admit about her understanding of mental health and the negative impact it has on families. She held an open discussion
following the film that engaged children, young people, parents and professionals and which ultimately received a standing ovation.

This conference ran between 3.00 and 8.00pm in a Greek Church in Camberwell on 26th March 2014 and was attended by over 200 people.

**BME Volunteers event:**
An event jointly hosted with MASSADA BME Volunteer SLaM Project which goes onto inpatient wards at the Maudsley and into BME community projects e.g. Peckham Befrienders and the Rafiki Project – based at the African Advocacy Foundation whose volunteers are Mental Health Champions in the wider community.

The event was an opportunity to give key messages to the black community to increase understanding of mental health and how and why volunteers make a huge difference to the care and experience of mental ill health. It brought together small communities to show case how they are helping and getting involved.

This event attracted over a 120 people at the Ortus centre, which included a whole range of people from service user projects, volunteers, SLaM staff, community projects past and present leadership and members and ran from 6.30pm to 9pm on 30th October 2013

**Examples of Training offered:**

**Spiritual and Pastoral Care in mental health**
This is a 10-week course designed to attract faith leaders/faith groups. The course runs once a week, in the evenings, with over 100 people trained so far, and is about to commence its 8th Cohort. There has always been a waiting list with good representation from male, female and mature adults and, more recently; more young people have started attending.

While the course is open to all faith groups Black majority churches have chosen to seize the opportunity to learn more about mental health. As a result it has increased understanding of mental health and where to go for help. It has also started to be a source of volunteers for the Trust. The course has provided opportunities to develop relationships beyond the course and increase the promotion of good mental health at other faith events [such as, a women’s conference, a health conference, church services and funeral services] to audiences ranging from 50 to 400 strong, in some cases with international impact. The courses have also increased participation in other community events and training programmes.

**Introduction to the Values and Principles of Adult Social Care**
This training includes cultural competence and is part of a volunteers programme recently accredited and run by MASSADA. It engages BME people from diverse professional backgrounds and people who have lived experience of mental illness who wish to volunteer in mental health services. The majority of participants are from African Caribbean and African backgrounds. Saturday courses often have up to 26 people; and ultimately reach people on wards, carers, families, staff and projects within the community.

- Research and development work
- Wheel of Wellbeing promotion
- KHP Happier at Work Programme
The Recovery and Social Inclusion Board

The Trust has had a Social Inclusion and Recovery (SIR) Strategy for a number of years. The SIR Board is chaired by Gabrielle Richards, Head of Occupational Therapy and Lead for Social Inclusion and Recovery. It meets on a quarterly basis and oversees a number of work programmes that aim to promote recovery, social inclusion and mental well-being for the benefit of service users and the wider population in line with the key priorities in the Trusts overall strategy. The SIR Strategy has been the vehicle for implementing these priorities. Implicit in all of these strands of activity is the principle of co-production and involvement from service users, their supporters and carers.

For the past 4 years the Trust has been involved in a national network called IMROC (Implementing Recovery through Organisational Change) which identify ten key organisational challenges that represent the key areas of change required in the practice of mental health workers, the types of services and the culture of organisations. The SIR Board has used these challenges to frame the focus of their work for SLaM to become a more recovery-oriented organisation. The Challenges are:

1. Changing the nature of day-to-day interactions and the quality of experience
2. Delivering comprehensive, user-led education and training programmes
3. Establishing a “Recovery Education Unit” (Recovery College) to drive the programmes forward
4. Ensuring organisational commitment, creating the “culture”
5. Increasing personalisation and choice
6. Changing the way we approach risk assessment and management
7. Redefining user involvement
8. Transforming the workforce
9. Supporting staff in their recovery journey
10. Increasing opportunities for building a life “beyond illness”

SLaM provides many opportunities for service users and carers to become involved and contribute in a variety of ways many of which are illustrated through involvement in Trust activity, which is reflected in the 10 organisational challenges. These vary in both character and scale and are continually increasing as the Trust seeks to establish recovery-oriented services as the norm. In a large and complex organisation undergoing continuous and significant change it is not a straightforward operation to capture the full extent of the opportunities for service uses and carer involvement as there is a wide spectrum of activity some seen, much unseen. The following are some examples of involvement.

The SLaM Recovery College [www.slamrecoverycollege.co.uk](http://www.slamrecoverycollege.co.uk)
The College delivered its first 2 weeks of pilot courses in July 2013. SLaM service users and carers had already played a major part in the delivery of Education and Training programmes through such initiatives as SUITE but the establishment of the Recovery College has provided opportunities to co-produce and deliver educational programmes which recognises professional and lived experience expertise. The College is providing an employment route for people with lived experience and an educational model of staff, service users, their carers and supporters of learning together as students that focuses on self-management, skills building and prevention, underpinned by the values of hope, control and opportunity.

A second programme ran from Oct to Dec 2013, which built on the number of courses and venues. The Recovery College formally launched with the Spring-Summer term 2014 commencing on April 29th. The programme has expanded to 38
courses and workshops (some repeated) in 9 venues across the Trust. Two weeks into the term there are 186 people enrolled and approximately 650 places on courses booked (75% of courses are already fully booked) including 20% of bookings from staff. There is significant interest in the College and it is growing.

Volunteering
SLaM currently provides opportunities for service users and carers to contribute directly to the delivery of services as volunteers, undertaking administrative and other skilled tasks that are of mutual benefit to them and the service they support. There are a number of initiatives and it is only in the last 18 months that we have been able to develop sound governance, training and reporting structures with the advent of a coordinator role across the Trust. The post holder has worked with services to develop suitable volunteering opportunity and is linked in with KHP. There are over 300 people registered through this scheme, and approximately 40% of these volunteers have lived experience. The demand is growing and evidence is being gathered to identify destinations of those who have volunteered e.g. routes into employment.

Peer Support
Peer support is provided through a number of routes and mechanisms. We need to work on identifying what we as an organisation mean by peer support and how we intend to develop it. Some roles are paid and others are carried out through volunteering or informal peer networks. Some are offered as part of SLaM services and some are offered through other agencies. It is a wide spectrum of provision and activity, often unseen and unreported. As described at the Executive meeting (7/5/14) there is a desire to increase peer support activity and in particular peer support workers within the Trust as a way to demonstrate the Trust’s commitment to having peer support and self-management as one of its foundation building blocks. We do collect data on what peer support there is in the Trust for the Quality Account but the figures are limited to the positions directly supervised by Trust staff with responsibility for the activity concerned, or to activity that is funded by the Maudsley Charity to be carried out by a partner organisation for the benefit of service users. Over the past year there has been a steady increase in peer support as defined above, but the numbers remain small (see quality account Q4 2013-14). However we recognise this does not fully capture the true extent of activity both formal and informal.

In summary, it is important to state these are only a small number of examples of the range of involvement opportunities for service users and carers under the auspices of the SIR Board. Equally the issue of sustainably and mainstreaming is significant as both the Recovery College and the Volunteer coordination are limited Charity funded projects yet crucial to supporting the Trust strategic plan to include peer support and self-management.

- Audit

Over the past 10 years there have been ongoing audits undertaking within the Trust through the Clinical Governance Team. Some of these audits include service users and carers. Examples of the audits with patients and carers include:

1. Patient Information: Including inpatient information trolleys and information stalls throughout a number of GP Surgeries
2. Service culture
3. Food and Nutrition
Example of involvement work from 2 CAGs
MAP – involvement: 2013/2014

- Contributing to improvements or developments
  - E.g.: Advisory groups, Involvement register
  - Open events, forums, focus groups etc.
  - 600 people

- Facilitating involvement, supporting management
  - E.g.: Substantive posts, Paid Trainers, Volunteers
  - 18 people

- Service Delivery
  - 12 people

- Giving Feedback -
  - 2500 people
Psych Med Involvement 2013/14

- Contributing to improvements or developments
  - E.g.: Substantive posts, Paid Trainers, Volunteers
  - E.g.: Advisory groups, Involvement register
  - Open events, forums, focus groups etc.

- Giving Feedback -
  - 2350 bits of feedback

- Facilitating involvement, supporting management
  - 260 people

- Service Delivery
  - 25 people

15 people
References

1. The King's Fund 2012, Patients' Preferences Matter
2. NHSE Bite-size guides to support patient and public participation in the NHS, 2013/4
3. NICE Service User Experience in Adult Mental Health 136, 2012
4. NICE CG136 Service user experience in adult mental health: slide set, 2011
5. SLaM Equality Impact Assessment, The Involvement Register and the Development of EPIC 2013
6. SLaM Our Involvement Approach, 2007/09
7. SLaM Patient Information Strategy 2010
10. SLaM Patient and Public Involvement: An Approach, 2012 (not ratified)
TRUST BOARD OF DIRECTORS – SUMMARY REPORT

Date of Board meeting: 27th May 2014

Name of Report: Finance Report

Heading: Performance & Activity

Author: Tim Greenwood, Mark Nelson
Finance Directorate, BRH

Approved by: Gus Heafield
(name of Exec Member)

Presented by: Gus Heafield

Purpose of the report:

Action required:
To note the contents of the report and the financial position. Members of the Board of Directors to satisfy themselves that actions are appropriate to address issues arising in order to ensure that the Trust meets its financial targets for Q1 and the next 12 months in line with the operational plan.

Recommendations to the Board:
That the Trust Board of Directors:
approves the report on the financial position for April 2014
approves the basis for the completion of the Reference Costs for 2013/14; and
notes the progress on the annual accounts for 2013/14

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:
The report identifies activity and financial pressures that if not resolved may have implications on the Trust’s ability to deliver its equality, diversity and patient involvement commitments as set out in the Annual Plan

Service Quality Implications:
The report identifies potential activity and financial pressures that if not resolved may have implications for the delivery of the Trust’s quality commitments in the Annual Plan.
South London and Maudsley NHS Foundation Trust

Finance Report 2014/15 – April 2014 (month 1)

1. Summary

- The financial performance for the first month of the financial year is analysed below.
- The Trust Board is required to approve the methodology to be used in computing reference costs prior to submission. The summary requirements are set out in an Appendix to this report.
- The Trust Audit Committee meeting will be reviewing the final versions of the Annual Report and Accounts at its meeting in the morning of 27th May. There is a separate Board agenda item on 27th May for a report back from the Audit Committee meeting. Copies of the final draft annual accounts will be distributed to members of the Board of Directors prior to the Board meeting so they can raise any questions or issues for the Audit Committee to take into account in its considerations.

2. Headlines

The finance report is based on month 1 performance. As Board members will appreciate there are usually more one-off items in the results for the first month of the year and also there are still issues arising from the process for finalisation of the budgets in line with the operational plan. Where appropriate these have been flagged in the report. The finance and performance teams working with the CAGs are aiming to ensure absolute clarity in these planning and budgeting issues by the time that the month 2 actuals are available and I expect that the month 2 position will give a much clearer indication of potential performance issues through the figures than month 1. The operational plan timetable means that we are able to ensure clarity in finalised budgets earlier than in previous years.

- The finance report will be increasingly aligned with the performance report which is a separate item on the agenda.
- The overview of the financial performance at month 1 is:
  i) £0.2m net deficit (£0.1m) adverse variance from plan – see Table 1
  ii) £1.2m EBITDA (£0.1m) adverse variance from plan – see Table 1
  iii) If this variance was to continue, a risk rating of 3 would be achieved in Q1. This is due the cash position of the Trust rather than the income and expenditure position
  iv) With the transfer of overspending forensic placements to NHS E, the closure of 2 loss making specialist services and additional funding for Triage/HTT expected in Croydon, the financial position of the Trust has improved in certain areas. However there remain on-going issues that need to be addressed and which are causing the current position to be £0.1m off plan -

- Whilst responsibility for forensic placements transferred to NHS England, the Trust still holds the budget for many non-forensic placements in Lambeth, Southwark and Lewisham. At month 1 these placements were £0.2m overspent – an unsustainable level of activity – with one Local Authority planning further reductions in cost (potentially £0.75m) that is not factored into the figures stated here. The action plan for addressing the pressure and clarifying the commissioning issues is due before the month 2 results.
• Cost and Volume Income is behind target by £0.07m in month 1 but this variance has significantly reduced compared with £0.5m shortfall for March 2014 as a result of the closure of NDS and AED which were making significant losses. Further work is underway in planning the trajectories for these services including potential for further investment which will be resolved by month 2.

• Individual ward nursing costs/budgets remain to be resolved. The methodology for ensuring safe staffing and the financial modelling and budgeting of the ward establishments is subject to a separate review by the Audit Committee this month. Additional funding has been set aside to increase nursing establishments in certain areas. This funding is currently held in reserves (although feeding through to the bottom line position) and will be allocated to specific wards/units once final agreement is reached. The month 1 position shows a variance in CAGs of £0.1m, which is matched by central budgets which will be transferred to CAGs once the ward budgets are signed off on behalf of the Board. The current pressures relate mainly to MHOA, particularly the continuing care homes. The work on safer staffing is expected to have concluded to enable us to establish new ward budgets in time to feed into the month 2 position and we would expect there to be no significant variances in the reported position next month.

• One-off issues have impacted on the CEO budgets and other infrastructure financial performance in month 1 - overall the infrastructure budgets are expected to hit their targets this quarter.

• £4m of CIPs were not identified in the Plan and are impacting on the month 1 position by £0.3m. Additional CIPs of £1.7m which were based on Trustwide changes have outline plans but are still subject to further detailed planning. These latter schemes have been planned to deliver the savings later in the year and so are not impacting at month 1. Current CIPs with plans total £15.8m and at month 1 planned delivery was £0.9m. Some slippage in performance in month 1 is attributable to two specific schemes in Psychosis and MAP. These are likely to be phasing issues at month 1 but where slippage has been confirmed in the Gresham PICU changes a replacement scheme has been identified in Psychosis.

• 3 CAGs have been shown net of central adjustments in relation to their plans in respect of 2013/14 transitional funding removed pending a review of their financial positions and agreement to new financial targets:

  - Psychosis: removal of £2.9m of transitional funding but with overspends on placements, drugs and community staffing also helping to drive the position
  - B&D: removal of £2.3m of transitional funding but with forensic services trading at a forecast deficit of £4m. The cost of these services remains significantly above the price that NHS E appear willing to pay for them
  - Addictions: removal of £1.4m of transitional funding but with inpatient services trading at a forecast deficit of £0.5m. The AA Unit is continuing to not meet its activity targets (45% occupancy in month 1) even though prices are set at below full cost

v) The current position includes the following assumptions -

• CCG QIPP plans totalling £3.9m remain to be agreed and are excluded from the month 1 position

• £1.7m of Trustwide CIPs are being developed and are not included at month 1. They will be phased in once detailed plans have been agreed

• £4m of CIPs remain to be identified and are feeding into the month 1 position as an adverse variance

• CCG and NHS England contracts have yet to be signed off and therefore assumptions have been made as to the ultimate value of these contracts
- Funding of up to £2.2m remains in dispute with Southwark CCG regarding the transfer of Specialist services in 2013/14. This is not reflected in the month 1 position.
- Final R&D funding levels have yet to be notified. The month 1 figures are therefore in line with the Plan until funding is confirmed.
- £2m of funding has been set aside in reserves for investment in various areas across the Trust and this will be released in line with financial performance as appropriate and to ensure progress on our strategic targets.
- CQUIN schemes are expected to deliver to generate CQUIN income at 100%.
- Additional CCG income for acute OBDs has been phased in line with the activity plan. This will result in a reduction in income in the second half of the year when the impact of investment in the AMH model is expected to take effect.

3. Financial Summary (prior to new-year budget adjustments to be actioned by month 2)

<table>
<thead>
<tr>
<th>Service Analysis</th>
<th>Full Year Live Budgets (£)</th>
<th>Year To Date Actual (£)</th>
<th>Variance From Live Budgets (£)</th>
</tr>
</thead>
<tbody>
<tr>
<td>01. Psychosis</td>
<td>98,064,900</td>
<td>9,369,400</td>
<td>667,300</td>
</tr>
<tr>
<td>02. Behavioural And Dev. Psych</td>
<td>0</td>
<td>468,000</td>
<td>468,000</td>
</tr>
<tr>
<td>03. Mood, Anxiety, Personality</td>
<td>1,518,300</td>
<td>196,200</td>
<td>38,500</td>
</tr>
<tr>
<td>04. Psychological Medicine</td>
<td>889,300</td>
<td>55,300</td>
<td>(18,800)</td>
</tr>
<tr>
<td>05. Child &amp; Adolescent Service</td>
<td>2,302,000</td>
<td>115,400</td>
<td>(90,100)</td>
</tr>
<tr>
<td>06. MHOA And Dementia</td>
<td>570,100</td>
<td>95,800</td>
<td>48,300</td>
</tr>
<tr>
<td>07. Addictions</td>
<td>0</td>
<td>98,500</td>
<td>98,500</td>
</tr>
<tr>
<td>08. Clinical Support Services</td>
<td>1,766,200</td>
<td>161,800</td>
<td>14,600</td>
</tr>
<tr>
<td>09. Infrastructure Directorates</td>
<td>48,781,700</td>
<td>4,221,300</td>
<td>287,000</td>
</tr>
<tr>
<td>10. Corporate Income</td>
<td>(106,296,800)</td>
<td>(9,024,700)</td>
<td>16,400</td>
</tr>
<tr>
<td><strong>Operational Deficit (prior to budget adjustments to be actioned at month2)</strong></td>
<td>47,595,700</td>
<td>5,757,000</td>
<td>1,529,700</td>
</tr>
<tr>
<td>11. Corporate Other</td>
<td>(88,420,000)</td>
<td>(6,973,800)</td>
<td>201,100</td>
</tr>
<tr>
<td>12. Contingency - planned</td>
<td>2,405,000</td>
<td>0</td>
<td></td>
</tr>
<tr>
<td>13. Contingency - committed</td>
<td>14,381,966</td>
<td>0</td>
<td></td>
</tr>
<tr>
<td>14. Other reserves/provisions released</td>
<td>8,018,434</td>
<td>0</td>
<td>(1,584,772)</td>
</tr>
<tr>
<td><strong>Corporate Other</strong></td>
<td>(63,614,600)</td>
<td>(6,973,800)</td>
<td>(1,383,672)</td>
</tr>
</tbody>
</table>

**EBITDA**

|                     | (16,018,900) | (1,216,800) | 146,028 |

| 15. Post Ebitda Items | 15,085,000 | 1,385,100 | (6,900) |

**Trust Financial Position**

|                     | (933,900) | 168,300 | 139,128 |
### 3. Key Cost Drivers

#### Psychosis & B&D - 12 Month Rolling Run Rates

<table>
<thead>
<tr>
<th>Month</th>
<th>Surplus/Deficit £000's</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>-1,500</td>
</tr>
<tr>
<td>2</td>
<td>-1,000</td>
</tr>
<tr>
<td>3</td>
<td>-500</td>
</tr>
<tr>
<td>4</td>
<td>0</td>
</tr>
<tr>
<td>5</td>
<td>2</td>
</tr>
<tr>
<td>6</td>
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<td>8</td>
</tr>
<tr>
<td>12</td>
<td>9</td>
</tr>
<tr>
<td>1</td>
<td>10</td>
</tr>
</tbody>
</table>

**Note** – transitional funding removed in month 1. Forensic placements transferred to NHS E from 1/4/14. NDS closed in Q4 13/14

#### Area Variance

<table>
<thead>
<tr>
<th></th>
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<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Ward Nursing</td>
<td>(131)</td>
<td>25</td>
<td>(79)</td>
<td>(167)</td>
<td>(276)</td>
<td>(2,214)</td>
<td>(130)</td>
</tr>
<tr>
<td>Acute Overspill</td>
<td>(440)</td>
<td>555</td>
<td>(274)</td>
<td>(140)</td>
<td>(193)</td>
<td>(2,379)</td>
<td>0</td>
</tr>
<tr>
<td>Unmet CIPs*</td>
<td>(498)</td>
<td>(399)</td>
<td>(139)</td>
<td>(242)</td>
<td>(106)</td>
<td>(3,218)</td>
<td>(160)</td>
</tr>
<tr>
<td>CPC/C&amp;V Income</td>
<td>(447)</td>
<td>(561)</td>
<td>(191)</td>
<td>(549)</td>
<td>(462)</td>
<td>(4,163)</td>
<td>(68)</td>
</tr>
<tr>
<td>Placements</td>
<td>(77)</td>
<td>(54)</td>
<td>(48)</td>
<td>(72)</td>
<td>(109)</td>
<td>(2,333)</td>
<td>(213)</td>
</tr>
<tr>
<td>Total</td>
<td>(1,593)</td>
<td>(434)</td>
<td>(731)</td>
<td>(1,170)</td>
<td>(1,146)</td>
<td>(14,307)</td>
<td>(571)</td>
</tr>
</tbody>
</table>

* excludes the acute overspill CIP as this is reflected explicitly in the row above.
Performance against the main cost drivers is detailed below –

- **Acute/PICU Overspill**

Overall, 34 beds were used outside the Trust in April, an increase of 5 compared to the previous month. The increase from March is largely accounted for by the closure of Gresham PICU and transfer of remaining activity to external placements. Trust capacity is due to increase with the opening of additional Triage beds at the Bethlem in June. Other measures being taken to reduce the use of acute beds include:

- **Screening and prioritisation of admission** A senior medical manager on call system has been in place for the last month and has been extended to mid June. The senior medical manager on call screens all admissions and instructs ward reviews at weekends for any patients admitted who they feel may be able to be discharged the next day.

- **Delayed discharges** A daily review of all delays across acute, private and rehab beds has been in place since February which ensures that delays are minimised and includes cross CAG escalation as necessary. This has increased capacity.

- **Daily demand and capacity teleconference** this happens daily across AMH Clinical Service Leads (CSLs) and matches demand and capacity to ensure best use of beds and quick agreement as to troubleshoot capacity problems

- **Data analysis** A new data set will be developed for approval by the end of May. This will be provided to each borough Medical Advisory Committee and discussed to support benchmarking

- **Quality improvement project** The North Lambeth Psychosis CMHT have implemented a new type of clinical daily meeting and follow up process during 2014. Initial data suggests a significant reduction in OBDs from this team following this project. The same approach to daily clinical meetings will roll out across all Psychosis community teams during June, to be complete by the end of June.

- **Use of HTT** In Lambeth and Lewisham, HTT will attend the Psychosis community team meetings 3 times a week to take on cases and hand back cases. It is anticipated this will lead to earlier use of HTT and therefore support admission avoidance.

- **Review of Patients** A review by the Psychosis community team CSLs of the crisis plans of all high readmission patients will be finalised by June 15th

The Trust has risk shares in place with its local CCGs.

The teams have been working hard to reduce private sector overspill in line with the plan trajectory and investment in OBDs from CCGs. As at 19 May 2014 private sector overspill stands at 19 AMH (incorporating 4 patients referred out of PICU) and 2 PICU patients who currently require on-going PICU provision. The month 1 figures assume that overspill and internal capacity is funded within the CCG investments and this will be confirmed in terms of the trajectories by month 2.
- **Ward/Unit Nursing Costs (Table 2)**

At month 1 ward nursing costs were overspent by £130k, a reduction on the 2013/14 average. The Director of Nursing has been reviewing ward nursing establishments in line with the safe staffing for inpatient services requirements and additional funding has been set aside within the plan to implement the outcomes of this work which is due to be reflected in local budgets by month 2. The highest overspends are occurring in MHOA continuing care homes £93k after one month).

- **Complex Placements**

Forensic placements transferred to NHS E at the start of the year having overspent by £2.3m in 2013/14. However the Trust is still responsible for other placements in Lambeth, Southwark and Lewisham. In month 1 these placements were overspending by £213k. 67% of this overspend relates to one borough and in which the Local Authority is intending to reduce its funding contribution further. Discussions are taking place with the CCG/Local Authority to establish an appropriate level of funding. Small risk shares are in place in Lambeth and Southwark.
• Cost per Case/Cost and Volume

The position has improved compared to 2013/14 largely due to the closure of the AED and NDS units that reported a shortfall in income of £3.3m last year. In addition, activity on the Psychosis Unit is ahead of target compared to a £0.6m shortfall in 13/14. There remain ongoing concerns as regards the Addictions Assessment Unit where activity was below 50% in April (and as low as 17% at certain times).

<table>
<thead>
<tr>
<th>CAG</th>
<th>Income Target At Month1 £'000</th>
<th>Actual invoiced At Month1 £'000</th>
<th>Surplus/ Deficit(-) At Month1 £'000</th>
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<tr>
<td>Psychosis</td>
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<td>Behavioural &amp; Dev</td>
<td>1,597</td>
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<td>1,778</td>
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<td>Addictions</td>
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<td>TOTAL</td>
<td>6,078</td>
<td>6,009</td>
<td>(69)</td>
</tr>
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</table>

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 2014/15.

4. Cost Improvement Programme (CIP) & CCG QIPP

a) Trust CIP (Table 4)

The Trust is reporting an overall adverse variance of £160k (17%) at month 1 against its original identified plan of £15.8m CIPs for the year.

The main areas of variance are the delay in closing Gresham PICU and continuing pay overspends in MAP A&T teams which were planned to be addressed by month 2. The Psychosis CAG have identified an alternative scheme to compensate for the shortfall in the Gresham PICU scheme. We expect the programme office for Trust productivity and efficiency to be established by month 2 and this will have a key role alongside the Executive in improving performance and establishing a rolling programme of improvements. There remains £4m of unidentified CIPs which are currently feeding into the bottom line position of the Trust.

b) CCG QIPP (disinvestment) - Table 5

Detailed plans to meet the aggregate £3.9m QIPP targets have yet to be agreed. The Trust will not sign up to savings plans that cannot be delivered and discussing are ongoing with our local CCGs and NHS England.

5. Local CCG Contract Positions

Contracts with our 4 local CCGs have yet to be signed. The main outstanding financial issues are largely to do with QIPP and whether the plans to remove funding are reasonable or not –

• Lambeth - c£1.5m of QIPP schemes remain to be agreed.
• Southwark – c£1.3m of QIPP schemes remain to be agreed. No agreement has yet been reached with the CCG regarding the 13/14 transfer of funding to NHS E for specialist services.

• Lewisham - c£1m of QIPP schemes remain to be agreed. Discussions continue regarding investment into the AMH model.

• Croydon – still in discussion regarding the level of level of investment into acute beds and HTT.

6. Trust Summary Issues and Actions

The Trust Executive and CAGs are focussed on delivery to the financial plan for Q1. Further work is underway to establish appropriate budgets within the CAGs following the finalisation of the Operational Plan. This will be completed by the time of publication of the month 2 results.

The Trust and CAGs have been reviewing non-essential expenditure and additional controls in order to ensure the stabilisation of the financial position in this first quarter. This is often one of the most challenging periods given the significant changes in financial budgets and targets between the financial years.

Specific areas for attention by month 2 are highlighted within the report and we will be working on closer alignment and integration with the performance report this quarter.

In particular the Trust needs to make progress in the following areas in time for month 2 and where possible more quickly:

• Finalisation of contracts with local CCGs and NHS England particularly for forensic services, clarification of QIPP requirements, and outstanding issues between NHS England and NHS Southwark

• Finalisation of the bed trajectory and AMH programme metrics for the year

• The action plan for addressing the pressure in the remaining placements budgets (£0.2m at month 1) and clarifying the commissioning issues.

• The work on safer staffing is expected to have concluded to enable us to establish new ward budgets in time to feed into the month 2 position and we would expect there to be no significant variances in the reported position next month.

• Further potential for income in C&V services to be identified and recognised by month 2 results.

• Start up of the efficiency and productivity programme office and process for establishing the rolling programme of improvements

• Finalisation of the financial targets for BDP, Psychosis and Addictions CAGs

Gus Heafield
Chief Financial Officer
May 2014
Reference Costs 2013/14

**Introduction**

The reference cost guidance for 2013/14 has recently been published alongside mental health PbR guidance and like last year, the Trust Board is required to approve by minute, the methodology to be used in computing reference costs prior to submission. Specifically Boards or their appropriate sub-committees are required to confirm that:

a) costs will be prepared with due regard to the principles and standards set out in Monitor’s Approved Costing Guidance
b) appropriate costing and information capture systems are in operation
c) costing teams are appropriately resourced to complete the reference costs return accurately within the timescales set out in the reference costs guidance
d) procedures are in place such that the self-assessment quality checklist will be completed at the time of the reference costs return.

There are also a couple of areas of developing methodologies the board is asked to determine its favoured approach.

**Methodology**

The total quantum of costs is calculated for the whole Trust, which is effectively the operating cost for providing NHS funded activities - ie excludes non-NHS income. All costs are allocated / apportioned to front line services, in line with the NHS Costing Manual, based on agreed apportionments for intra-CAG costs, occupied area for Estates, usage for catering and domestics and front line pay costs for Trust overheads

Services are identified on two measures, whether they are clusterable and whether the type of activity is contact or OBD. Non clusterable services are classified as “excluded” and reported separately in the reference cost return as either OBD cost or contact cost. Clustering services essentially include adult and MHOA services, which are not classified as either specialist or secure ie excluded from the Prescribed Services list commissioned by NHS England, or specifically excluded from clustering.

Trust-wide activity reports encompassing all activity from 1st April 2012 to 31st March 2013 are produced by the information team and then matched against service fully absorbed costs. The service cost is divided by the service activity to obtain an average activity cost for each service. For non-clusterable services this is as far as the calculations are taken, thereby producing either an average OBD cost or an average contact cost.

**Clustering Methodology**

The service cost is then allocated to clusters based on the proportion of the activity in each cluster. All individual service cluster costs are then totalled, by cluster, to create a Trust cost for each cluster. The days in cluster is calculated separately, for all patients and the Trust total cost per cluster is then divided by the total days attributable to each cluster, to produce an average daily cost per cluster.

Although the objective is to calculate the average daily cost per cluster, the cost is subdivided into initial (cluster) assessments, non-admitted patient care and admitted patient care.

**Developments**

Following their normal reference costing submission, acute hospitals will submit PLiCS-based HRG costings and they will self-assess their costing accuracy against the HFMA Acute Clinical Costing Standards by way of the Materiality and Quality Scores (MaQS) template. The HFMA Mental Health Clinical Costing Standards are now published and it is recommended that MH providers also make a PLiCS and MAQs return.

Going forward to improve costing quality and in line with MONITOR costing guidance, our systems need to move towards a Patient Level information Costing System (PLiCS), which is likely to be challenging currently with the various bespoke systems used in SLaM. If in future years, PLiCS is mandated for mental health then any failure to meet the target could become a Monitor governance issue.

However, MONITOR wants to move beyond PLiCS to a Time Driven Activity Based Costing (TDABC) methodology, as proposed by Professor Robert Kaplan and Professor
Michael Porter – MONITOR “Approved Costing Guidance 21 February 2013”. Since the largest part of our costs is labour it might be simplest for us to rebase our costs on this basis and miss out the PLiCS step. This would require close clinical engagement with finance and would require detailed work to be undertaken with many different representative teams and if to meet the deadline for next year, work would have to start as soon as reference costs have been submitted in July 2014.

Recommendation

The approach taken by the Trust is in line with the requirement of the guidance and on this basis I am requesting that the Board of Directors approve the methodology for the calculation of reference costs and specifically that:

a) costs will be prepared with due regard to the principles and standards set out in Monitor’s Approved Costing Guidance

b) appropriate costing and information capture systems are in operation

c) costing teams are appropriately resourced to complete the reference costs return accurately within the timescales set out in the reference costs guidance

d) procedures are in place such that the self-assessment quality checklist will be completed at the time of the reference costs return

Gus Heafield
Chief Financial Officer
May 2014
Date of Board Meeting: 27th May 2014

Name of Report: Summary Performance Report, April 2014

Heading: Performance

Author: Nick Dawe, Chief Operating Officer

Approved by: Nick Dawe, Chief Operating Officer

Presented by: Martin Baggaley, Medical Director

Purpose of the report:

To report the Trust’s performance against the Operational Plan 2014/15 Targets, identify any major areas of learning and success, identify and analyse under performance and provide action plans to address such under performance.

Action required:

To review the progress being made with the Operational Plan 2014/15, consider the robustness and timing of actions to address issues and to identify areas where a more detailed report will be required in June.

Recommendations to the Board:

To approve the report, noting that it is a draft format and observations around layout and level of detail would be welcomed.

Relationship with the Assurance Framework (Risks, Controls and Assurance) and level of assurance provided by the report - none, low, moderate, high:

Key operational control, assurance level moderate.

Summary of Financial and Legal Implications:

No additional financial implications or benefits identified.

Equality & Diversity and Public & Patient Involvement Implications:

None.

Service Quality Implications:

None.
Introduction

This report is the first version of the Summary Performance Report that brings together a Trust wide view of performance from team to Board level.

The Summary Performance Report reflects four perspectives; Quality, Programs, Operations and Resources.

The report concentrates on issues, analysis and actions illustrated with figures where appropriate. A full statistical report is available upon request and in future months will be available on the “desktop”.

To assist in understanding the report uses the; Red, Amber Green performance flags and the; Deteriorating, Holding, Improving direction of travel flags.

OVERALL PERSPECTIVE

Compared to the last quarter of 2013/14 the Trust has improved its position in respect of quality, programs, operations and resources, though there remain significant issues to address in the first quarter.

QUALITY PERSPECTIVE

- CAGs have reviewed the content and in the main have ensured that quality indicators are a good reflection of what happens on the ground floor i.e. level 4 and reconciles with what CAGs are using routinely to monitor services
- Quality Account as previously presented to the Board. Work is on-going in defining clearly the measures and reports for each of the nine areas of the quality account and this is due for completion by the end of the month
- CAGs have also included in this area delivery of the Trusts’ action plan in response to the Francis Report
- Performance in terms of Monitor and CQINN targets at Trust level is at the required level however not all CAGs are reaching their specific targets.
PROGRAM PERSPECTIVE

- CAGs have further defined the programs of work for the year. We will need to ensure reconciliation with the Operational Plan and reporting to the Board.

- AMH Program – key project areas identified, timetable agreed (Gantt chart available) and initial dashboard of measures agreed with local CCG. Re-alignment of community teams (MAP) taking place. Recruitment to new post currently taking place.

- Forensic action plan currently being implemented. Still outstanding contractual issues to be resolved in respect of transitional support and QIPPs.

- Capital and Statutory Maintenance Program to plan and has been flexed to respond to changing service preferences around ward locations and capacity requirements.

OPERATIONAL PERSPECTIVE

- Activity is in general over performing for IPs, but within the level of operational and financial contingency planned. This in part will trigger risk share agreements with CCGs.

- Complaints: specific issue for Psychosis, of complaints waiting over 6m for a response. CAG requested to take a more pragmatic approach to resolving immediate issue and then looking at how to prevent this from happening again and achieve responses in less than 4 weeks.

- 7 DFU: across the Trust we are borderline in meeting this target for M1 (awaiting response from CAG who are reviewing with care co-ordinators).

- CPA 12m review: specific issue in MHOAD where results are below target. This is due to the performance of one particular team and senior management are addressing this. Psychosis also under performing (93.0%).

- HTT gatekeeping: performance is c. 85% pending further validation against a target. It has now been agreed that only members of the HTTs can admit to wards between 08.00 to 22.00. Senior medical staff is also on call until midnight. This will improve performance and we also look at the recording of supporting evidence.

- CAMHS patients in adult beds – this is reported to DH weekly. Medical Director and Clinical Director for CAMHS fully involved. Plans in place to repatriate CAMHS patients back to the Trust as soon as possible.

RESOURCE PERSPECTIVE

- Subject to a separate report.
**INDIVIDUAL CAG PERSPECTIVE**

**Psychosis**

*Complaints:* The numbers of Psychosis complaints which have been open for more than six months is 51 (Report Run Date: 06 May). An additional 32 complaints have been open for over three months. **Action,** the CAG is working to remove all backlog of complaints (in excess of one month) by 30th June. Support to be offered by Nursing and Operations Directorate

*Activity:* Wards are working at 100% capacity with overspill placements beginning to reduce to plan. **Action,** enhanced monitoring in place further bed management initiatives in train, private unplanned overspill to cease by end of June.

*Observations:* Observations costs are high but the overall trend is downward.

*Transport:* Issues with invoices related to transportation were raised, lack of clarity on who is responsible for payment, and cross checking the invoices is difficult. **Action,** further transport review to take place over next three months ending July 2014 led by Operations.

*NHSP Issues:* Unfulfilled requests from for agency staff not classified appropriately. Actual performance of NHSP not correctly represented. **Action,** issue to be taken forward with NHSP by HR for resolution by end of June.

**AMH**

*Staffing:* So far the plans have proceeded well with good engagement from the consultants, all the teams are relocated in the right buildings and training plans are in place. The next big piece of work is the recruitment and national recruitment drive is planned.

*Accommodation:* Shortage of good accommodation for the Lewisham teams, with the MAP waiting to see if suitable properties become available in the primary care and will inform the Board before it reaches the crunch stage. **Action,** issue being addressed through the Capital Program, longer-term solutions form part of the draft Estates Strategy.

**PSYMED**

*HTT:* With a very narrow interpretation of the Monitor definition, the Trust’s HTT performance for April would be 81%. However, if we take a more favourable interpretation of the exemptions, in cases where the Monitor definition is ambiguous, the Trust’s performance will be 85%. Taking a step further, and if include the admissions to PICU wards as we have done in the past, the Trust’s performance will be 88%. **Action,** CAG to review all data and ensure compliance to requirement by end of May.
**BDP**

**7 Day Follow Ups:** Two follow-ups missed out of nine with one a missed opportunity due to lack of understanding of the definition. **Action, CAG to review all data and ensure compliance to requirement by end of May.**

**Activity:** Issues with meeting high occupancy target set by NHS E without impacting on quality and operational flexibility. **Action, CAG to review by end of June whether expanded bed complement would allow target to be met but appropriate location, staffing numbers and service model critical to success.**

**IT Issues:** Delay in the procurement of computers for the prison project has caused difficulties. **Action IT to resolve by end of May.**

**CAMHS**

**Children Admitted to Adult Wards:** There have been number of admissions in the past few months where children have been admitted carefully, selectively and after detailed clinical review to adult wards due to national bed shortage. CAGs assured that the all the right procedures are being followed.

**Activity:** In CMHT team, the CAG is holding regular meetings to reduce the waiting times, and looking into various options such merging teams. However, the lack of lower resource allocation is a long-standing issue in Croydon and has become an issue for Lambeth. CAG is actively working on reducing waiting times for wards and to get patients into wards quickly, keeping the partners informed. **Action CAG will make the timeline available for the Board assurance by end of May.**

**ADDICTIONS**

**Data Analysis:** CAG has access to large quantity of data as the government bodies publish copious amounts of data but the CAG lack the resources to analyse the data in any meaningful way. **Action, Medical Director in discussion with CAG to review options to carry out value healthcare analysis by end of July.**

**MHOAD**

**Activity:** Memory service has 80 new referrals a month. Need for new premises for all memory service teams to build KHP offering raised. **Action option for new location identified and discussion around release of space in train, with new premises operational by end of March 2015 latest.**

Significant underperformance for CPA 12m review. **Action, CAG to review all data and ensure compliance to requirement by end of May.**
FORWARD LOOK

**Contracting:** All contracts are due to be finalised by end of May, however the date for finalisation due to continuing discussions on the detail of QIPPs and AMHH Transformation means that the long stop date of 14th June is the new target (only major uncertainty is with NHS E).

**Activity:** In the first two weeks of May a significant reduction in overspill required with PICU being better than expected and adult mental health broadly to target. More recently pressure has grown again and the situation is subject to a series of detailed actions.

**Programs:** From July it is planned that targets for the IT, HR and OD and Commercial programs will have been agreed and be performance managed from that point.

FURTHER DETAIL

The figures and analysis supporting this report are available on request.

Nick Dawe

Chief Operating Officer

21st May 2014
**TRUST BOARD - SUMMARY REPORT**

<table>
<thead>
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<th>Date of Board meeting:</th>
<th>27 May 2014</th>
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<tbody>
<tr>
<td>Name of Report:</td>
<td>Chief Executive’s report</td>
</tr>
<tr>
<td>Heading: - (Strategy, Quality, Performance &amp; Activity, Governance, Information)</td>
<td>Governance</td>
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<tr>
<td>Author(s):</td>
<td>Paul Mitchell, Trust Secretary</td>
</tr>
<tr>
<td>Approved by (name of Executive member):</td>
<td>Dr Matthew Patrick, Chief Executive</td>
</tr>
<tr>
<td>Presented by:</td>
<td>Dr Matthew Patrick, Chief Executive</td>
</tr>
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**Purpose of the report:**

To inform the Board of significant issues arising from the local health economy and nationally in the NHS and Social Care plus an update on information governance issues.

**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 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 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 the local health economy and nationally in the NHS and Social Care.

**Service Quality Implications:**

A number of the national issues listed in the report will have an impact on the quality of services provided by the Trust.
1. National issues

**NHS England warns of financial challenge ahead**

NHS England has warned of an even more challenging financial year than 2013-14 in an overview of the sector’s finances that revealed only one in four clinical commissioning groups have balanced plans. Board papers also pointed to “significant weaknesses” in its specialised commissioning budget. A report said a further risk to its finances was the very variable financial strength of CCGs – with end of year positions ranging from surpluses in excess of 8 per cent to deficits of over 5 per cent. The report warned that 2014-15 and the years to come would be even more challenging than the previous financial year.

These concerns have been echoed by Monitor, who have written to all Foundation Trusts offering them the opportunity to review their year 2 plans to make sure that these are not overly optimistic given the difficult nature of the financial environment.

**Psychiatric patients to receive physical health checks**

Mental health trusts are to be paid for carrying out assessments of the physical condition and lifestyle of psychiatric patients via a national CQUIN. NHS England says the scheme, which aims to cut the number of mental health patients who die from heart, liver and lung disease in particular, is the biggest initiative of its kind. The assessments will look at a variety of indicators including patients’ diet, weight, blood pressure and whether they smoke. Hospital patients will be among the first to be checked, especially those on anti-psychotic drugs. NHS England estimate that mental health trusts could earn up to £200,000 from carrying out the checks.

**Frimley Park hospital merger with Heatherwood and Wexham Park**

Frimley Park Hospital's plans to merge with two neighbouring Berkshire hospitals took a major step forward this week. The Competition and Markets Authority (CMA), the government department responsible for strengthening business competition and preventing anti-competitive activities, approved Frimley Park's proposed merger with Heatherwood Hospital in Ascot and Wexham Park Hospital in Slough. This will be the first ever merger between Foundation Trusts.

The CMA examined evidence from Monitor, clinical commissioning groups (CCGs) from the new Trust's proposed catchment area in Surrey, Hampshire and Berkshire, and the Care Quality Commission before reaching its decision. Patients and patient groups were also consulted during the review process.

The investigation ruled a merger would not lead to a material reduction in the quality of services for patients or levels of competition between hospitals in the area, nor a loss of choice for patients, CCGs or the NHS.
2. Trust issues

Integrated Care
In my role as lead KHP Executive for integrated care I have taken part in a number of meetings over the past month with local stakeholders including General Practice, CCGs, Local Authorities, the Southwark and Lambeth Integrated Care (SLIC) leadership group and Sponsor Board and SLIC providers as a group. These conversations have focused on how local providers can organise themselves to provide a whole system response to the challenge of improving the health and lives of local people within a contracting financial envelope.

General Practice and KHP, together with Social Care, will be key in organising this response. Mental health has much to contribute to these developments, in part because some 80% of our services are already delivered within community settings; but also because of the high levels of mental health comorbidity with long term physical conditions and the very high associated cost, both in terms of lives less lived and financially. I am hoping to bring a more substantial paper to the Board in the near future.

Black Mental Health UK & South London and Maudsley NHS Trust on treatment of black patients
On 13th May 2014 I met with Health Minister, Norman Lamb MP and Black Mental Health UK’s (BMH UK) director Matilda MacAttram to talk about the concerns from BMH UK over the treatment received by people from the African/Caribbean community within mental health Trusts. We also discussed the work that is taking place to improve the community’s confidence in our services in particular, and the very positive work that is taking place between SLaM and the Met Police.

The work of SLaM is of particular importance for Black Mental Health UK, given that we are responsible for the delivery of mental healthcare to the parts of London that are home to the largest numbers of people from the UK’s African Caribbean communities living in England.

Discussions between the Trust and BMH UK will continue as we develop community based, culturally appropriate early intervention care so as to improve this groups experience of mental health services.

3. Congratulations

Bedlam
We are delighted that Bedlam, our four-part documentary series, has scooped a BAFTA television award.

The four-part documentary series SLaM made with Channel 4 and Garden Production was declared the winner of the ‘best factual series’ category at a prestigious ceremony at the Theatre Royal, Drury Lane, London.

Bedlam, a series about patients and staff at South London and Maudsley NHS Foundation Trust, fought off stiff competition to claim the award.
Maudsley Learning Centre
The Maudsley Learning and Events Centre has won a prestigious RIBA Regional Award for its innovative design.

The centre won the education category of the London regional section of the awards, which celebrate the best of British architecture. The centre was also shortlisted in several of the RIBA specialist awards categories with nominations for the Sustainability Award, Client of the Year and London Architect of the Year. It was also one of four final projects identified as achieving the highest level of architectural resolution, for London Building of the Year, selected from the 33 Regional Award winners.

The venue has already won a clutch of awards including a Brick Award 2013 – Best Education Building and Supreme Winner; ACA’s Innovation in Partnering Awards – Highly Commended; listed as one of Sunday Telegraph’s top five buildings of 2013 a winner of a Civic Trust Award 2014 and the Association of Civil Engineers has shortlisted the centre as best small project for their forthcoming awards.

3 Dimensions of Care for Diabetes team wins BMJ award
The 3 Dimensions of care For Diabetes (3DFD) team took home the Diabetes team of the Year award at the BMJ awards on Thursday 8 May. Professor Khalida Ismail, Consultant Psychiatrist in Diabetes, was part of the winning team

3DFD is a King’s College Hospital based team that provides and integrates mental health and social interventions for people with poorly controlled diabetes who live in Lambeth and Southwark. The service is delivered at King’s College Hospital and at Guy’s and St Thomas’ Hospitals, as well as in the community, to ensure the highest quality of integrated biopsychosocial care.

3DFD has completed 2 consecutive pilot phases during which the components of the service has been refined and effectiveness demonstrated. It has received funding from NHS London, hospital charities (Guy’s & St Thomas’, King’s College and Maudsley) and Lambeth and Southwark CCGs.

The programme has successfully improved diabetes control and the reduction of complications for patients by addressing the psychological and social barriers to diabetes self-management as well as delivering diabetes care. 3DFD has also led to improvements in unscheduled care, such as decreases in A&E attendances and hospital admissions.

4. Information Governance
The investigation into the serious confidentiality incident that was reported in January has been completed. The incident involved a sealed envelope containing a bundle of Lewisham and Guy’s Mental Health NHS Trust documents with personal confidential data dating back to 1996-97 that was posted through the letter box of an unintended recipient. Immediate actions were taken to ensure that the documents were fully recovered and no confidential information was still at large.

As part of the investigation, further checks were made to identify if other documents with personal confidential information may be at risk. The Trust electronic health records system was reviewed to locate digitised versions of the documents among records that were
transferred from the Lewisham and Guy's NHS Mental Health Trust from where these documents originated. It appears the documents were never part of the health records that were transferred from the Lewisham and Guy's Mental Health Trust to the Trust.

As the incident relates to documents that originated from an organisation that ceased to exist in 1999 and the documents date even earlier, the investigation was not able to identify the source of the data breach. However, due to the efforts of the investigation team and the co-operation of former staff, it has been possible to identify records management process in Lewisham and Guy's Mental Health Trust.

The investigation report outlines lessons to be learned and action plan arising from the findings of this investigation. There has been considerable progress against these actions to date, which are being monitored by the Trust Caldicott Committee.

The incident was reported externally to the Information Commissioner's Office in line with the national information incidents reporting process. The investigation report and progress updates on the action plan have been provided to the ICO.

Dr Matthew Patrick  
Chief Executive  
May 2014
Date of Board meeting: 27 May 2014

Name of Report: Report from the Council of Governors

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

Author: Paul Mitchell, Trust Secretary

Approved by: (name of Exec Member) Dr Matthew Patrick, Chief Executive

Presented by: Noel Urwin, 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.

Service Quality Implications:
The Council of Governors’ bids programme specifically welcomes bids which “improve the patient experience”.
1. Change of Non Executive Directors

The Council of Governors unanimously agreed at a recent special meeting the appointment of two Non Executive Directors who will take up their appointments in mid June for three year terms.

Lesley Calladine has been appointed as Non Executive Director leading on Quality and Safety and Alan Downey will be the Non Executive Director leading on Commercial Development.

Lesley is Vice President, Health and Safety, BP Ltd. She has considerable experience in the area of risk, safety and compliance and a track record of leading and supporting change, driving up safety and quality standards for businesses.

Alan is Chair of KPMG’s Public Sector Practice. He brings a strong leadership track record and has advised major Whitehall departments on issues ranging from deficit reduction to reform of the criminal justice system.

At the same time Kumar Jacob and Harriet Hall are stepping down after serving for a number of years as Non-Executive Directors. Kumar will also step down as Chair of the Maudsley Charity. They are both thanked for the huge contribution they have made to running of the organisation.

2. Changes to the Council of Governors

Catherine McDonald will not be standing again as a Councillor at next week’s elections so will no longer be the stakeholder governor from Southwark Council. Catherine has been thanked for the contribution that she made to the Council of Governors. Southwark Council will make another nomination following the relevant meetings in June.

An updated list of Governors and their membership of the working groups will be brought to the next CoG meeting in June.

An update on proposed changes to the FT Constitution will also be brought to the June meeting.
3. Membership development and communications group

The group met on Wednesday, 14th May 2014. Revised terms of reference were agreed.

Progress reports were received on the members' discount scheme, implementation of Plain English and the planning for the “Happy Heads” festival in July.

The development of a membership marketing strategy will be considered further at the next meeting.

4. Quality group

A meeting of the Quality group will be taking place on Tuesday, 20th May.

Updates will take place on progress on the formation of Trust Quality Committee, Auditor's comments on the Quality Accounts and the implementation of MHA Tribunal paper-only hearings.

Regular consideration is also made on the Trust’s Service Quality Indicator Report and the National Staff Survey.

Paul Mitchell
Trust Secretary
May 2014
TRUST BOARD OF DIRECTORS – SUMMARY REPORT

Date of Board meeting: 27th May 2014

Name of Report: KHP Board Verbal Update

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

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

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

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

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

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

Service Quality Implications:
A key driver of the AHSC is the improvement of the quality of the services offered to local people and beyond. This has recently been tested via the accreditation process. Of specific importance to mental health is the closer integration and parity with physical health care.
Date of Board meeting: Tuesday 27 May 2014

Name of Report: Audit Committee Chair’s verbal report following the Audit Committee’s consideration of: (1) SLaM’s 2013/14 Annual Report and Accounts; and (2) Safe Staffing report

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

Author: Steven Thomas (Audit Committee Secretary)

Approved by: Robert Coomber (Audit Committee Chair and Non Executive Director)

Presented by: Robert Coomber (Audit Committee Chair and Non Executive Director)

Purpose of the report: To inform the Board of the Audit Committee’s comments and conclusions regarding:

(1) SLaM’s 2013/14 Annual Report and Accounts; and (2) Safe Staffing report

The Audit Committee considered these documents at its meeting held on the morning of Tuesday 27 May 2014 – hence the verbal nature of the report from the Audit Committee Chair

Action required: Receive the verbal reports from the Audit Committee Chair

Recommendations to the Board: Note the verbal reports from the Audit Committee Chair and approve SLaM’s 2013/14 Annual Report and Accounts

Relationship with the Assurance Framework (Risks, Controls and Assurance) and level of assurance provided by the report - none, low, moderate, high:
The Assurance Framework supports preparation of the 2013/14 Annual Report and Accounts

Summary of Financial and Legal Implications:
The results for the year and the information in the 2013/14 Annual Report and Accounts affect assessments made by the Independent Regulator (‘Monitor’)

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

Service Quality Implications:
The 2013/14 Annual Report and Accounts include the Quality Accounts, which cover service quality matters
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