

**A MEETING OF THE MEMBERS' COUNCIL OF  
THE SOUTH LONDON AND MAUDSLEY NHS FOUNDATION TRUST  
WILL BE HELD ON THURSDAY, 11<sup>th</sup> MARCH 2010 AT 5.00PM  
IN THE LECTURE THEATRE, SOUTHWARK TRAINING CENTRE**

**AGENDA**

1 Introductions and apologies for absence.

2 To receive any declarations of interest.

**FOR DECISION**

3 To agree the minutes of the Members' Council meeting held on 11<sup>th</sup> December 2009 and to note any matters arising from the minutes. Attachment A

**FOR INFORMATION**

4 To note the summary of the joint meeting held between the three KHP Members' Councils. Attachment B

5 Update on the Members' Council bids programme. Attachment C

6 Update on the Annual Plan 2010/11. Verbal

7 Chief Executive's and Directors' reports. Attachment D

8 Trust Secretary's report. Attachment E

**FOR DISCUSSION**

9 Update by Gus Heafield on Financial planning – "Downside Scenarios". Presentation

10 Development of Clinical Academic Groups. Pack included

11 Forward planner – items for future meetings:

- AIQUIP
- Anti stigma "Time for Change" programme

12 Any other business.

13 Date of next meeting – Thursday, 10<sup>th</sup> June 2010.

**Please send apologies to Carol Stevenson telephone 0203 288 2441 or email [carol.stevenson@slam.nhs.uk](mailto:carol.stevenson@slam.nhs.uk)**

**Attachment A**

**MEMBERS' COUNCIL – SUMMARY REPORT**

**Date of meeting:** 11<sup>th</sup> March 2010

**Name of Report:** Minutes of the meeting held on  
10<sup>th</sup> December 2009

**Author:** Paul Mitchell, Trust Secretary

**Presented by:** Madeliene Long, Chair

**Purpose of the report:**

To agree the minutes and to note any matters arising.

**MINUTES OF THE MEETING OF THE MEMBERS' COUNCIL OF THE  
SOUTH LONDON & MAUDSLEY NHS FOUNDATION TRUST  
HELD ON THURSDAY 10<sup>TH</sup> DECEMBER 2009  
IN THE BOARDROOM, MAUDSLEY HOSPITAL**

<b>PRESENT</b>	Madeliene Long	Chair
<b>Public Constituencies</b>	Derrick Bentley	Public (Local)
	Stephanie Correia	Public (Local)
	Polly de Blank	Service User – Local
	Les Elliot	Service User (Local)
	Marion Heithus	Public (National)
	Stephen Hill	Public (National)
	Jaya Kathrecha	Carer
	John Muldoon	Public (Local)
	Paul Paterson	Service User (Local)
	Noel Urwin	Public (Local)
<b>Staff Constituency</b>	Abbey Akinoshun	Staff
	Francis Keaney	Staff
	Layla McCay	Staff
	Dele Olajide	Staff
	Gill Todd	Staff
<b>Partner Organisations</b>	Lorna Campbell	Lambeth Borough Council
	Lynn Carlisle	Kings College London
	Sophie Corlett	MIND
	Andrew Eyres	Lambeth PCT
	Jonathon Mitchell	Southwark Borough Council
	Magda Moorey	Lewisham PCT
	Jan Oliver	Guys and St Thomas's Hospitals NHS FT
<b>IN ATTENDANCE</b>	Martin Baggaley	Medical Director
	Cliff Bean	Deputy Director, Patient Safety & Assurance
	Stuart Bell	Chief Executive
	Charles Bland	Non Executive Director
	David Blazey	Social Inclusion, Rehabilitation and Recovery Project Manager
	Chris Clare	Non Executive Director
	Richard Dyer	Member
	Harriet Hall	Non Executive Director
	Gus Heafield	Director of Finance & Corporate Governance
	Hilary McCallion	Director of Nursing and Education
	Paul Mitchell	Trust Secretary
	Louise Norris	Director of Human Resources
	Zoe Reed	Director of Strategy & Business Development
	Gabrielle Richards	Head of Occupational Therapy
	Carol Stevenson	HQ Administrator
<b>APOLOGIES</b>	Roger Oliver	Carer
	Crada Onuegbu	Lewisham Borough Council

Ref	Issue	Who	When
MC 09/32	<p><b>DECLARATIONS OF INTEREST</b></p> <p>Standing declarations - Madeliene Long and John Muldoon made declarations as Councillors for the London Borough of Lewisham.</p>		
MC 09/33	<p><b>MINUTES OF PREVIOUS MEETING - MEMBERS' COUNCIL</b></p> <p>The minutes of the meeting held on 15<sup>th</sup> September 2009 were <b>agreed</b> as an accurate record subject to the following amendments:</p> <ul style="list-style-type: none"> <li>• The venue was Glaziers' Hall not Maudsley Boardroom.</li> <li>• Add Chris Clare to those In Attendance.</li> <li>• Add Sophie Corlett to Apologies.</li> </ul>	CS / PM	
MC 09/34	<p><b>MINUTES OF PREVIOUS MEETING – JOINT BOARD OF DIRECTORS AND MEMBERS' COUNCIL MEETING</b></p> <p>The minutes of the meeting held on 27<sup>th</sup> November 2009 were <b>agreed</b> as an accurate record subject to the following amendments:</p> <ul style="list-style-type: none"> <li>• Add John Muldoon and Lynn Carlisle to Apologies.</li> </ul> <p>The workplan produced following the meeting was considered.</p> <p><b>AGREED:</b></p> <p>Two additional working groups should be established to cover communications and quality. Otherwise, the workplan for 2010 was agreed.</p>	CS / PM	
MC 09/35	<p><b>QUALITY UPDATE</b></p> <p>Cliff Bean gave a presentation on Quality.</p> <p>He highlighted the issues currently driving the quality agenda nationally:</p> <ul style="list-style-type: none"> <li>• The new regulatory framework (CQC)</li> <li>• The overall economic position</li> <li>• Darzi report – quality accounts</li> <li>• Service users' expectations</li> <li>• Pressure on PCTs to improve the quality of commissioning</li> </ul> <p>Initiatives on quality locally included:</p> <ul style="list-style-type: none"> <li>• Productive ward programme - Releasing Time to Care</li> <li>• Patient Experience group</li> <li>• Lean processes</li> <li>• MAGNET (nurse-driven excellence)</li> </ul>		

	<ul style="list-style-type: none"> <li>• Development of a quality strategy</li> </ul> <p>Cliff Bean suggested a number of questions for the Members' Council to consider:</p> <ul style="list-style-type: none"> <li>• How can members engage with the quality agenda?</li> <li>• How to build quality into existing programmes?</li> <li>• How to engage in the development of the quality strategy and quality accounts?</li> </ul> <p><b>Discussion points:</b></p> <ul style="list-style-type: none"> <li>• Should service user feedback be included in staff appraisal?</li> <li>• Continuity of service is important for service users</li> <li>• Quality development requires sufficient time to be made available for staff.</li> <li>• Good work is being done with carers and families on how to engage positively with professionals.</li> <li>• Utilise information from complaints to ensure lessons are learned</li> </ul> <p><b>AGREED:</b></p> <p>Work should be taken forward via the quality working group.</p>		
<p><b>MC 09/36</b></p>	<p><b>BIDS PROGRAMME</b></p> <p>Noel Urwin updated on the uptake of bids in the 2009 programme. It was noted that the rate was far higher than in the previous year.</p> <p>David Blazey presented a detailed analysis on the themes he had identified in the 2009 'Make me Smile' programme. He suggested that the overall spread of themes was similar to the previous year.</p> <p>Gill Todd presented the plans for an evaluation day to be held in the late spring. She urged the Member's Council to show their support by attending on the day.</p> <p><b>AGREED:</b></p> <ul style="list-style-type: none"> <li>• The themes identified should be fed into the Trust's annual planning process.</li> <li>• As KHP has 'embrace wellbeing' as an objective the Trust should talk to KHP partners about the value of the bids programme.</li> <li>• The bids programme should be evaluated by an external organisation.</li> </ul>		

<p><b>MC 09/37</b></p>	<p><b>CHIEF EXECUTIVE'S REPORT</b></p> <p>Stuart Bell presented his report summarising current Trust and national health care issues.</p> <p>He explained that the 2008/09 Annual Health Check has found that the Trust's quality of services were "good" and use of resources were "excellent". There were three areas that had pulled the quality of services from "excellent" the previous year. He confirmed that action plans are being put in place to address these issues.</p>		
<p><b>MC 09/38</b></p>	<p><b>DOWNSIDE SCENARIOS</b></p> <p>Gus Heafield gave a presentation on the current and projected financial environment.</p> <p>He explained that as a result of the downturn in the economy, financial plans had been submitted to Monitor in September 2009 outlining a number of potential scenarios.</p> <p>He emphasised that there would also be severe implications for partner organisations in local PCTs, Local Authorities and higher education.</p> <p>These issues were being worked through via the business planning process and in negotiations with other stakeholders. This would require ongoing engagement with Members' Council.</p> <p><b>AGREED:</b></p> <p>This would be discussed further at the Members' Council meeting in March 2010.</p>		
<p><b>MC 09/39</b></p>	<p><b>FUTURE MEETINGS</b></p> <p>Thursday 11<sup>th</sup> March 2010 at 5.00pm (venue TBC)  Thursday 10<sup>th</sup> June at 5.00pm (venue TBC)  Tuesday 14<sup>th</sup> September 2010 at 3.30pm (venue: Glaziers Hall)  Thursday 16<sup>th</sup> December 2009 at 5.00pm (venue TBC)</p>		

PNJM / CMS December 2009

Z: members council / meetings / 2010 03 11 / app a minutes 2009 12 11

**MEMBERS' COUNCIL – SUMMARY REPORT**

**Date of meeting:** 11<sup>th</sup> March 2010  
**Name of Report:** Joint Governor's meeting  
**Author:** Paul Mitchell  
**Presented by:** Paul Mitchell

**Purpose of the report:**

- To update the Members' Council on the outcome of the joint Governors meeting held on 12<sup>th</sup> January 2010.

## **Joint Governors meeting**

A joint meeting of the Members' Councils / Board of Governors from Guy's and St Thomas' NHS Foundation Trust, Kings College Hospital NHS Foundation Trust and the South London and Maudsley NHS Foundation Trust was held on 12<sup>th</sup> January 2010 at Kings College Hospital. This was very well attended and those who came heard presentations from Prof Robert Lechler on the progress and plans of Kings Health Partners and Prof John Moxham on CAG development.

Attendees were asked to identify three areas where as governors they could help to make the AHSC more patient focused and visible. Feedback included:

- Develop links with health partners, GPs, social care, commissioners
- Increase the understanding of the AHSC amongst governors
- Develop KPIs which measure performance of service delivery to the local population
- Run competitions for patients and the public to suggest ways of improving health
- Provide information to patients on the benefits of participating in research trials

There was general agreement that a similar forum should be arranged three times a year to which other stakeholders could be invited.

An evaluation has been carried out by Guy's and St Thomas' NHS Foundation Trust. The majority response was that the meeting was enjoyable and that the event fulfilled its objective.

Paul Mitchell  
Trust Secretary  
March 2010

Z: members council / meetings / meeting 2010 03 15 / app b joint meeting

**MEMBERS' COUNCIL – SUMMARY REPORT**

**Date of meeting:** 11<sup>th</sup> March 2010

**Name of Report:** Members' Council bids programme update

**Author:** Paul Mitchell

**Presented by:** Noel Urwin supported by Magda Moorey and Gill Todd

**Purpose of the report:**

- To update the Members' Council on progress with the bids programme 2009, to note proposals for evaluation of the scheme and progress on the previously agreed event in 2010

## **MEMBERS' COUNCIL BIDS PROGRAMME 2009 UPDATE**

### **1. Bids received and funded**

45 (out of 47) successful applicants have received funding for their projects.

The themes identified in the 2009 programme were considered at the meeting of the Members' Council held in December 2009. These have been forwarded to the Trust executive for consideration as part of the business planning process.

### **2. Evaluation of bids**

A proposal has been received from the New Economics Foundation to carry out an evaluation of the 2009 bids programme (attached). It is intended that this work is completed in time to feed into the event scheduled for (confirm day) June 2010.

### **3. Event 2010**

The Bids Steering Group previously recommended that an event is held in the early summer of 2010 so as to acknowledge the successful bidders and provide feedback to the unsuccessful. This will also help launch the 2010 programme.

The event has been confirmed for (confirm day) June 2010 at (confirm time).

Noel Urwin  
Members' Council

## ‘Make me smile’ evaluation

### Concept note to South London and Maudsley NHS Trust

This concept note sketches out a proposed plan for the evaluation of the ‘make me smile’ and the ‘can money buy happiness’ projects run by the Members’ Council of the South London and Maudsley NHS Trust. This is not a final proposal, but only a note to be discussed with the potential clients.

#### Research Questions

The overall questions to be answered by this evaluation are as follows:

- What things do people expect to increase their well-being?
- Who were the people who responded to the projects?
- What impacts did the projects have on people’s well-being?

The first two questions would be answered by analysing the applications made to the scheme. The latter question would be answered based on interviews with beneficiaries.

#### Applications

A random sample of ~60 applications to the schemes would be analysed (for example every 8<sup>th</sup> application). Each would be categorised according to what activity or purchase is being proposed. Applications would also be assessed against self-determination theory to speculate on what needs might be met by the application, and what motivations appear to be driving it.

To supplement this primary analysis of the applications, we will also interview 3 panel members who judged applications to draw from them any opinions they had about the applications in general.

Parallel with this, the demographics of the applicants would be compared with the local population to assess which age groups, ethnicities and localities were more or less represented amongst applicants.

#### Beneficiaries

A random selection of 20 beneficiaries of the schemes for whom contact details are available would be identified. These beneficiaries would be contacted by SLAM and asked if they would be willing to be interviewed by **nef** about their experience. Those

not willing to be interviewed would be replaced by other randomly selected beneficiaries.

Interviews will likely all be conducted by telephone to reduce time requirements. However, it may be feasible to arrange one day for face-to-face interviews in one or more localities in SLAM's area.

Interviews will seek to address the following research questions:

- did beneficiaries spend the money as they said they would? if not, why not?
- what short-term benefits did they report from the experience?
- what long-term benefits, if any, were there from the experience? did they learn anything from the experience?

Interviews will be recorded in note-form and Dictaphone. Main points will be drawn from notes for analysis, with recordings only used for quotes where necessary (full transcription will not be necessary).

### Outputs

The main output from the evaluation would be a short report on the findings together with a presentation of the findings to the client, in time for the upcoming event in June. The budget currently precludes any wider dissemination process.

**MEMBERS' COUNCIL – SUMMARY REPORT**

**Date of meeting:** 11<sup>th</sup> March 2010  
**Name of Report:** Chief Executive's report  
**Author:** Paul Mitchell  
**Presented by:** Stuart Bell

**Purpose of the report:**

To update the Members' Council on:

- Trust issues
- National issues

# Chief Executive's Report

March 2010

## 1. Trust issues

### Weather disruption

Once again, I would like to offer my thanks to all the staff who made the effort to come to work during early January in very difficult circumstances so that services could be maintained. The lessons learned from the snow last February seem to have stood the Trust in good stead, and contingency and business continuity planning has on the whole worked well.

### HIEC

I am pleased to report that the South London HIEC bid has been approved following competitive interviews in December. Further details of the funding agreed are to be confirmed following a challenge period.

### Joint meeting with NHS Lambeth

A joint meeting between the boards of SLaM and NHS Lambeth was held on 3<sup>rd</sup> February. The intention was to be able to share Trust and PCT strategies and to develop a mutual understanding and a clear analysis of what the Trust provided on behalf of Lambeth residents. It is hoped that we will use this format in meetings with the other local PCTs.

### Board development

The board has started taking part in a development programme run by McKinseys in order to strengthen the board's effectiveness in dealing with quality issues.

## 2. National issues

### The Operating Framework

The Operating Framework for the NHS in England for 2010/11 has been published and, for the third year in a row, the national priorities for the NHS remain consistent but NHS organizations are being urged to ensure that regional variation in performance is tackled. This will provide important stability in helping the NHS achieve the vision set out in *NHS 2010-15: from good to great. Preventative, people-centred, productive*, launched in December 2009. The Operating framework contains some significant guidance in relation to funding of emergency activity in acute care, the impact of which is being assessed by our KHP colleagues.

### Alcohol

The Health Select Committee has published their report on alcohol. They contend that the health harms resulting from alcohol misuse are underestimated. A minimum price for alcohol is advocated, with the Committee arguing that it is a myth that such a move would unfairly impact upon the majority of moderate drinkers. While the MPs state that education information campaigns and labelling will not change behaviour, they do believe that attitudes can be altered and make potent policy solutions more acceptable. The report also calls for the regulation of alcohol promotion to be completely independent of the alcohol and advertising industries.

**Swine flu**

The CMO reports that influenza illness consultation rates in England and weekly hospitalisation rates are decreasing in all age groups. There is also a continued significant decrease in the consultations to the NPFS which will therefore close on 11<sup>th</sup> February 2010. After this time, anyone who suspects they have swine flu is advised to contact their GP, who will be able to assess them and authorise antivirals if required. A national press campaign ran for a week from 8<sup>th</sup> February to inform the public of the closure of the service and the future arrangements to access treatment. The vaccination programme remains vital as swine flu is likely to be the predominant influenza virus during the 2010 flu season.

**Mid Staffordshire inquiry**

This has been described by one commentator as a sobering account of what happens when leadership fails to focus on the things that really matter to patients. Sir David Nicholson has asked that all boards read the report and review their standards, governance and performance in the light of this.

**Stuart Bell**  
**Chief Executive**  
**March 2010**

Z / members council / meeting 2010 03 11 / Chief Exec report mar 2010

**Attachment E**

**MEMBERS' COUNCIL – SUMMARY REPORT**

**Date of meeting:** 11<sup>th</sup> March 2010  
**Name of Report:** Trust Secretary's report  
**Author:** Paul Mitchell  
**Presented by:** Paul Mitchell

**Purpose of the report:**

To update the Members' Council on the following issues:

- Changes to the Members' Council
- Membership development.
- Communication with the membership
- Establishment of working groups
- Lead governor

To agree to hold by elections to fill vacancies on the Members' Council in June 2010.

To receive volunteers to join the recently established working groups.

## Trust Secretary's report

### 1. Changes to the Members' Council

We welcome Tim Smart, Chief Executive of Kings College Hospital NHS Foundation Trust who has joined the Members' Council replacing John Moxham.

Abbey Akinoshun has left the Trust which creates a vacancy from the staff constituency.

There are now 8 vacancies on the Members' Council:

Carer	1
Public – National	1
Staff	2
Service User – Local	1
Service User – National	3

It is **recommended** that by-elections are held in June to fill these vacancies which will be preceded by an awareness raising campaign.

### 2. Membership development

The current membership of the Foundation Trust is 9,584 as at 4<sup>th</sup> March 2010. The Trust remains on schedule to meet the target as set in the Annual Plan of 10,000 members by 31<sup>st</sup> March 2010.

### 3. Communication with the members

The launch of the SLaM members' website took place in August 2009. The intention is that this will help serve as an aid for recruiting new members as well as providing up to date information on Trust activity and scope for participating in on line forums. The site can be viewed at <http://www.members.slam.nhs.uk>. Version 2 of the site which includes some technical refinements will be available by the end of March. Wider discussions on improving communication with the membership will be taken forward by the communications working group (see below).

### 4. Working Groups

The following groups are being established:

- **Communications** – as agreed at the joint meeting with the Board of Directors with the aim of improving communication with the membership.
- **Quality** – following the presentation to the December meeting of the Members' Council it was agreed that this was an area where the Members' Council could make a valuable contribution.

- **Membership development** – as agreed at the joint meeting with the Board of Directors and specifically by developing links with:
  - Trust Wide Involvement Group
  - Local churches – especially BME
  - Voluntary sector
- **Bids programme 2010** – both to participate in the steering group responsible for running the programme but also to help with the assessment of the bids submitted as part of the 2010 programme.
- **Audit liaison group** – to help plan communication and contact with the Trust's external auditors.

In order to ensure their effectiveness it is **recommended** that further volunteers are required to serve on all of these groups.

## 5. Lead governor

Monitor has asked that all Foundation Trusts nominate a lead governor by 31<sup>st</sup> March 2010. The role as envisaged by Monitor is limited to a specific set of circumstances whereby Monitor would wish to communicate quickly and directly with the Members' Council. Further details of the role will be forwarded after the meeting and individuals interested in taking on the role will have the opportunity to put themselves forward.

Paul Mitchell  
Trust Secretary  
March 2010

Z: members council / meetings / meeting 2010 03 15 / app d trust secretary's report

# Clinical Academic Groups

## Overview March 2010

**Tracey Power**

# Time to reflect & review

- ❑ Even without the AHSC developments, challenges in the wider environment have provided drivers to fundamentally review how we do things - emphasis on **quality and continuous improvement**
- ❑ King's health partners offers an opportunity to promote health in mind and body by linking research, clinical services, education and training – genuine enthusiasm for a **holistic approach**
- ❑ Last year the main focus was on developing the overarching **strategy**, this year it is about aligning **organisational structures** to Clinical Academic Group structures
- ❑ **CAGs** are a managerial unit that draws in service, training & education and academic activities
- ❑ There is no right answer to how many CAGs there should be – there are **interfaces** no matter how we “cut it”
- ❑ Easy to get focused on the structures and the names – key aim is to focus on service **themes** and people with similar needs

# Clinical Academic Groups (CAGs)

- ❑ Bring together clinical and academic staff to deliver the ‘tripartite’ agenda – clinical, research, education and training working together to **improve the quality of services**
- ❑ Success ultimately measured by **service user outcomes and satisfaction**
- ❑ Provide **more focused and specialist services** and interventions based on consistent care pathways, clustered around a theme
- ❑ **Integrate physical, psychological & social** – emphasis on social care, recovery and interface between acute and mental health services
- ❑ **Enhance multi-disciplinary approaches** – leadership & team working
- ❑ **Empower teams to innovate** through Service Line Management – by making improvement demonstrable
- ❑ **Partnerships with stakeholders** – high level of engagement with service users and carers
- ❑ **Care pathway development** is a cornerstone of CAG development

# What's in a name?

- ❑ CAGs are really another name for “Department”, “Directorate” or “Division” – a managerial unit
- ❑ CAG services have been grouped according to themes and the names are broadly disorder based – reflects the way research is organised but services are organised more on needs and functions
- ❑ Some of the current CAG names are not helpful – need to identify alternatives
- ❑ We will be reviewing the names of the CAGs - ideas and thoughts welcome!
- ❑ Care pathways describe services in very practical terms – important to focus energy on these developments

# Progress so far with CAG development

- ❑ CAG structures confirmed - which SLaM services sit where and with which IoP academic departments
- ❑ Seven SLaM-specific and one cross-KHP CAG – Clinical Neurosciences
- ❑ MHOA, CAMHS and Addiction services map onto CAG structures fairly easily
- ❑ Behavioural & Developmental Psychiatry CAG brings behavioural and learning disorder and inpatient forensic services together in one structure
- ❑ Work is underway to reconfigure elements of Adult Mental Health services managerial structures to map onto Psychosis, Psychological Medicine and Mood Anxiety & Personality Disorder CAGs
- ❑ Service Directors and Academic Leads appointed to each CAG and plans to appoint Clinical Director

# Borough based partnerships

- ❑ CAGs mean developing alternative internal management structures that better reflect our intention to provide more focused and specialist services to people with specific diagnoses and needs
- ❑ At the same time, we will continue providing services suited to local communities, building on arrangements with Boroughs developed in the 10 years since SLaM was established
- ❑ Partnerships with Local Authorities, voluntary sector organisations, PCTs, users and carers still fundamentally important to the way we provide clinical services
- ❑ Need to address issues of inequity between services across our patch and also increase access to specialist support and care
- ❑ Need to manage on the basis of both local **AND** cross Trust perspective

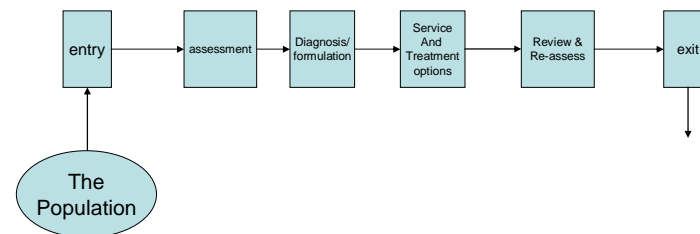
# Working across CAGs

- ❑ Many people have a range of needs and therefore need to access a range of services – requires co-ordination of services across different CAGs
- ❑ We are developing care pathways across all our services - ensure good communication between and across services that are in different CAGs
- ❑ Care pathways provide a clear and thorough description of every stage that is involved in receiving care and treatment
- ❑ People know what to expect from our services, what treatment options are available, what happens when
- ❑ Identifies a clear process for traveling between different services and different CAGs if that is what someone needs
- ❑ Care Pathway development is a priority - by developing these, we are going to look at what is the most sensible way to configure our services
- ❑ High level care pathways by April 2010 to be further refined and implemented thereafter

# Development of care pathways

- ❑ Many different definitions but most include the types of services/interventions that are provided and the timeline over which this happens
- ❑ “Care pathways are both a tool and a concept that embed guidelines, protocols and locally agreed, evidenced-based practice, into everyday practice for the individual patient” (NHS Protocols & Care Pathways Library)
- ❑ Hypothesis is that implementation will help improve care – e.g. reduce length of stay, improving multi-disciplinary collaboration, increasing evidence based practice, containing costs, enhancing patient empowerment
- ❑ Substantial clinical and service user engagement is essential

## A Common Chain



# Development of care pathways...

- What has been done already in SLaM and elsewhere
  - What processes will work best for us to engage a wide range of stakeholders
  - How we encourage service innovation & transformation
  - Providing supports e.g. champions, facilitators etc
  - Supporting CAGs to work with each other, and with other organisations
  - Achieving efficiencies, avoiding duplication & reducing waste
  - Agreeing level of standardisation so that we balance top down and bottom up approaches, ensuring “ must do” requirements incorporated etc
  - Review and evaluation so the process supports service redesign and continuous improvement in a systematic way
-

# Care pathway development timeframe

- Develop the high level pathways by April 2010 which set out a consensus of what might be considered an “ideal” pathway by key stakeholders
- Audit and review current practice and provision against the desired pathways (by autumn 2010)
- Develop new service models with associated changes in workforce (informing business planning priorities)
- Negotiate with commissioners about standard and enhanced pathways and how these are translated into service specifications and contracts (to inform contract for 2011/12)
- Develop process to formally sign off pathways at a Trust level
- Develop ePJS (clinical record) to support the ongoing monitoring and evaluation of the implementation of the pathways (incrementally during 2010/11)

# Service users' views and consultation

- ❑ Creating CAGs is about how we manage our services, research, education and training – internal organisational structures
- ❑ Care pathway development will help us make decisions about the best way of organising our clinical services based on best practice
- ❑ Emphasis on very inclusive approach to care pathway development
- ❑ If we propose any changes to the delivery of clinical services in the future, we will use the same processes for consulting as we do now – both formal and informal mechanisms
- ❑ We will continue to involve people at both a Trust level and a local level using both existing and new means

## **King's Health Partners**

### **Developments in South London & Maudsley NHS Foundation Trust**

#### **Progress report - February 2010**

#### **1) Introduction**

In June 2008, the Department of Health (DH) in their "High quality Care for all: NHS Next Stage Review Final Report" set out their expectations about developing a small number of Academic Health Sciences Centres (AHSCs). AHSCs are a way of working together over traditional organisational boundaries to integrate research, education, training and care. Thus there is a tripartite mission with an overall ambition of providing high quality, innovative care. Guy's & St Thomas, King's College Hospital and South London and Maudsley NHS Foundation Trusts and King's College London (University) developed proposals for a South London AHSC and in March 2009, King's Health Partners (KHP) was accredited as one of five UK AHSCs. This coincided with the first KHP conference. The core idea behind the KHP strategy is to streamline the process whereby people have good ideas about how to do things more effectively so that it is translated into practice far more rapidly. It is also about going upstream to intervene earlier and develop effective prevention strategies for whole communities. It is also about addressing the inequalities that currently exist in terms of health outcomes in our population.

#### **2) Governance**

The Academic Health Sciences Centre is a strategic alliance rather than a merger. This means that each of the four partners remains an organisation in its own right with its own governance structures. So the three NHS Foundation Trusts will each retain its Board of Directors and Board of Governors (or equivalent), and King's College London retains its Council.

The Partnership Board is the ultimate authority within King's Health Partners. Membership consists of the Chairs and Chief Executives of the three NHS Foundation Trusts and the Principal and Vice Principal of King's College London. Lord Butler of Brockwell was appointed as the first independent Chair of King's Health Partners in October 2009.

The Board:

- represents and promotes the interests of King's Health Partners
- is responsible for agreeing overall strategy and business planning, the nature and number of organisations within King's Health Partners and any other matters with potential or actual substantial impact on individual partners or the partnership
- will seek to prevent disputes and, if any occur, will resolve them in accordance with the binding dispute resolution procedure.

The King's Health Partners Executive team is led by Executive Director Professor Robert Lechler.

### **3) Health Innovation and Education**

In December 2009, King's Health Partners was part of a successful bid to become a Health Innovation Education Cluster (HIEC) - one of the new government funded networks aimed at delivering high quality patient care through better trained clinicians and faster translation and adoption of research and innovation.

South London HIEC is jointly led by south London's two major healthcare networks – the South West London Academic Health and Social Care Network and King's Health Partners. It includes all south London's primary care and mental health trusts, 17 NHS hospitals, the London Ambulance Service and the local Health Protection Unit, as well as six universities, further education providers and social care teams.

Members of the HIEC will work together to improve patient care and local health services by more rapidly delivering the benefits of research and innovation directly to patients, for example through the early adoption of new technologies and introduction of improved processes. Early work will include a review of current education and training aimed at health professionals across south London and is expected to lead to the introduction of new programmes, as well as enhancements to existing training courses.

The South London HIEC has identified four areas to focus on initially: mental health; infection prevention and control; diabetes, and stroke.

The Department of Health announced successful HIEC applications following a rigorous selection process, including a formal interview by the National Award Panel.

### **4) Clinical Academic Groups**

King's Health Partners have developed the concept of Clinical Academic Groups (CAGs) as the building blocks of the AHSC. They are a way of bringing people together to deliver the tripartite agenda and they provide a structure to support this. They bring together services and academic activity, clinical and academic staff, into an operational unit that can manage and deliver the AHSC agenda. There is no right answer to how many CAGs there should be, or indeed which activities/services sit in which. Further, it is important to think about these structures as a matrix as there are key overlaps between CAGs and indeed the cross cutting functions. There were many discussions during 2009 about the KHP CAG structure and although there are now firm proposals they will be subject to review as the plans are operationalised.

### **5) King's Health Partners level communication and engagement**

It is a huge task to communicate plans and engage stakeholders in the AHSC developments. There were numerous opportunities associated with the original proposals for KHP with stakeholder events taking place over the autumn and

winter of 2008. However, the recent priority has been the three month consultation on the overarching KHP strategy. This took place between July and September and local stakeholders were urged to contribute to this process as the KHP strategy will provide the framework for future developments and in particular the development of the CAGs. Two workshops for staff took place on the 28<sup>th</sup> and 29<sup>th</sup> July and there were two key events for wider stakeholders. There was a “working session” on 7<sup>th</sup> September and all senior contacts in partner organisations were encouraged to send representation. Also, SLaM hosted a Partnership Time Event on 11<sup>th</sup> September which aimed to bring together staff, users, carers and community groups to discuss the SLaM Carers’ Strategy and KHP Strategy. KHP is ensuring that their website is kept up to date and indeed is inviting ongoing contributions from stakeholders through this medium.

#### **6) King’s Health Partners Clinical Academic Group Events**

On 27<sup>th</sup> July, KHP invited senior leaders involved in CAG development across the four organisations to receive an update on progress and a half day follow up workshop took place on 4<sup>th</sup> November. At this event a number of CAGs presented details of their progress to the wider group and this included presenting their emerging strategies. All CAGs were offered the opportunity to display posters.

#### **7) King’s Health Partners and Clinical Academic Group developments in South London and Maudsley and the Institute of Psychiatry**

KHP provides an opportunity for SLaM and the Institute of Psychiatry, King’s College London (IoP) to develop and strengthen their existing close relationship. A series of workshops involving SLaM and IoP senior staff took place between November 2008 and May 2009. The purpose of these workshops was to consider the initial proposals for CAG structures and give people the opportunity to think about the potential benefits and challenges for service users, staff and other stakeholders. Staff were also asked to consider the future involvement of stakeholders in CAG development.

As a result of these discussions, a number of guiding principles for CAG development have emerged.

#### **CAGs will**

- Integrate academic, education, training and service delivery activities to improve the quality of services. The ultimate test of success is the outcomes for service users and their level of satisfaction.
- Provide more specialist services and more focussed interventions with an emphasis on more consistent pathways. Care pathway development is an important cornerstone for CAG development.
- Integrate physical, psychological and social approaches, the emphasis on social care, recovery and the interface between acute and mental health services.

- Enhance multi-disciplinary approaches with a particular emphasis on team working.
- Empower teams to innovate through Service Line Management. Having data to demonstrate efficiency and effectiveness.
- Have strong relationships with their stakeholders with a high level of engagement with service users and carers.
- Spearhead innovation by considering the interfaces with the other acute and mental health CAGs and the opportunities to reconfigure and transform services.

Subsequently, on 7<sup>th</sup> August the SLaM Executive confirmed the CAG structures in order that it was clear which services would sit in which CAGs (see appendix for details of CAGs as they relate to SLaM). Plans are now being developed to realign the existing managerial structures to reflect the CAG structures (so Directorates will be replaced by CAGs).

#### **8) CAG level communication and engagement plans**

Through recent discussions, it is clear that in addition to the initiatives that can be supported at a KHP and SLaM/IoP level, it is important to identify plans that are specific to individual CAGs and their key stakeholders. In terms of priorities for CAG development, these communication and engagement plans are as important as the work to develop the draft CAG Strategies. Those involved in CAG development have been asked to review their current circulation lists/consultation mechanisms in order to ascertain whether these might support the dissemination of information about CAG development and how stakeholders can contribute. It is particularly crucial that local commissioners are fully involved and indeed that plans are developed to focus on their role in CAG development. CAGs are being asked to develop tailored plans for their particular stakeholders and it is proposed to supplement this with SLaM/IoP level workshops. It is important to identify examples of opportunities and developments that demonstrate the practical benefits of CAGs and this needs to sit alongside proposals for the development of care pathways.

#### **9) Engagement workshops**

SLaM ran six half day workshops in November (9<sup>th</sup>, 10<sup>th</sup> & 11<sup>th</sup>). Each workshop had 100 places and was facilitated by staff from SLaM Partners (internal consultancy service) as well as members of the Trust Executive and management teams. Staff from all parts of the Trust were encouraged to take part irrespective of role or grade. As well as providing staff with the opportunity to contribute their ideas, the workshops also included an update on the latest developments within King's Health Partners and the plans to establish Clinical Academic Groups. The objective was to hear from staff about how SLaM can build upon the things that it does well, where it needs to do better and how staff think their role or service could change to improve the quality and effectiveness of the care provided. A follow up event has been arranged for 29<sup>th</sup> March.

On the 19<sup>th</sup> November, SLaM held the second Partnership Time Event focusing on CAG development and quality improvement and this was attended by approximately fifty users, carers and their representatives. It was agreed that regular events would be planned for 2010 and bi-monthly workshops have been arranged. A further event took place on 6<sup>th</sup> January and the next meeting will be on 16<sup>th</sup> March. It has been suggested that these might be focused on particular CAGs as well as providing a forum for a general progress report. In addition, the Trust level user consultation forum, Trust Wide Involvement Group (TWIG) is in the process of setting up a CAG development sub group to provide support and advice at the organisation level. It is expected that this will complement existing local mechanisms for working in partnership with stakeholders.

On 7<sup>th</sup> December there was a workshop for PCT and Local Authority Commissioners. Forty people attended the workshop. Half were from SLaM (representatives of the SLaM Executive and other key infrastructure leads) and half were commissioner representatives (all local commissioners were represented). The workshop included a presentation from SLaM, a question and answers session and then table work in mixed groups to identify priorities for action. One of the key action points was the need to develop a joint communication and engagement plan as there are large number of developments in the wider service system and it is important that key messages are shared with stakeholders effectively. It was agreed that regular meetings would be scheduled for 2010 and the next workshop is arranged for 15<sup>th</sup> April.

#### **10) Identifying the structures to support the local CAG developments**

As well as the Trust/loP level workshops, there have been discussions happening at a more local level and particularly about setting up steering groups or committees to work with existing Directorate and academic management teams to develop the CAG tripartite strategy and translate this into business/service plans for 2010.

The SLaM Board has agreed proposals to realign the existing managerial structures to reflect the CAG structures. There are seven SLaM focused CAGs and one cross KHP CAG, Clinical Neurosciences. Some existing SLaM managerial structures map fairly easily onto CAGs e.g. Mental Health of Older Adults (MHOA), Child & Adolescent (CAMHS), and Addictions. The Behavioural and Developmental Psychiatry CAG brings together behavioural and learning disorders with inpatient forensic services. Work is underway to reconfigure elements of adult mental health managerial structures to match Psychosis, Psychological Medicine and Mood Anxiety & Personality Disorder CAGs. Service Directors have been identified for each CAG and the loP has appointed interim academic leads as a result of realigning its departments to mirror CAG structures. Appointments to Clinical Director roles will follow shortly.

#### **11) Local services**

SLaM is looking at the balance between local and specialist services and will continue to have strong relationships and presence within the local communities. Working with communities and influencing the broader agenda

through joint planning mechanisms is a key priority e.g. public health, prevention and promotion, well being, enhancing engagement etc. Also key is health and social care integration and managing service systems, partnerships with social services, education and the third sector. It is important to focus on pathways across primary, secondary and tertiary services, integrating services within one service system and one management structure. There are opportunities to further develop relationships with primary care and this will rely on developing new incentive structures for early intervention and prevention. This could be part of the agenda to support commissioners with the development of polysystems and other service models based on care away from hospital. Further, there are opportunities to support the personalization agenda (personal budgets and self-directed care) through the development of the Mental Health Payment by Results framework (Association of Directors of Adult Social Services, June 2009).

SLaM also needs to consider increased access to specialist support and care and this relies on a critical mass for most specialist services. This also involves a balance between access for local commissioners and those further afield. It is important to address issues of equality and consistency of access to services. So it is clear that SLaM needs to manage on the basis of both the local and cross Trust perspective. On a practical level, the majority of services will continue to be based on close association with local boroughs. However, there are opportunities to explore the possibility of constructing a different care pathway for those with specific needs. For example, inpatient treatment for depression where currently patients generally are in a minority on the local general adult wards (where most patients have psychosis). One possible development would be a depression ward that serves the whole Trust area.

## **12) Strategic Context and financial climate**

SLaM's own strategy has synergies with King's Health Partners and the new national mental health strategy "New Horizons in mental health". There is a common emphasis on research into practice and on recovery, social inclusion and wellbeing. However, there are also a number of important factors in the wider environment to take into account. The financial downturn, potential changes in commissioning structures, the focus on quality and efficiency, disinvestment, demand management, service redesign and Payment by Results. Additionally, since SLaM has existed for over ten years in its current form, it is a good time to take stock and reflect.

In terms of managing the quality agenda, SLaM wishes to further develop its internal processes to meet regulatory and commissioning requirements, making the most of data and information management capability. This needs to include having objectives that are shared with commissioners to produce better outcomes and improve service user experience. The priority is to develop a culture of continuous improvement based on LEAN methodology (more value, less resources). This will drive service redesign and transformation. It is integral to the development of care pathways and CAGs.

### **13) Care pathway development**

The SLaM Executive has agreed that care pathway development is a key building block for CAG development and that it is a key means to engage wider stakeholders appropriately. This was discussed at the Senior Leadership Event (bringing together senior managers across SLaM) on 24<sup>th</sup> September and was a key agenda item at the SLaM annual conference on 16<sup>th</sup> November. At this event, a resource pack for CAGs to support care pathway development was launched (influenced by the NHS London Mental Health Clinical Care Pathway Group Report 2008) and a detailed plan supporting this work is being developed. Part of this includes providing the input of Service Improvement leads in order to support maximum engagement of stakeholders. It has been agreed that the first articulation of the CAG care pathways should be available by April 2010 although this will clearly be work in progress. The CAG Development Groups have been organising a number of initial events and workshops designed to bring together people to start thinking about the care pathways. It is acknowledged that many of the pathways are quite high level in the first iteration and there will much further work undertaken to refine and robustly implement them.

### **14) Support from the SLaM Communications Department**

Communications have begun the process to develop material to support the discussions with stakeholders. They have produced a document "Frequently Asked Questions – Clinical Academic Groups" which has been updated as a result of the engagement workshops. They have also set up a CAG site on the Trust Intranet and this will be extended to the Trust's Internet site when it is relaunched in the spring. The idea is that the site will contain a range of information that would support discussions about CAG development. For example, containing the KHP Strategy and SLaM Strategy documentation as well as specific information pertaining to CAG development. Members of the SLaM Executive have been asked to take every opportunity to ensure that these developments are on the agenda for all key meetings and especially those with key partners (e.g. with commissioners/local authorities etc).

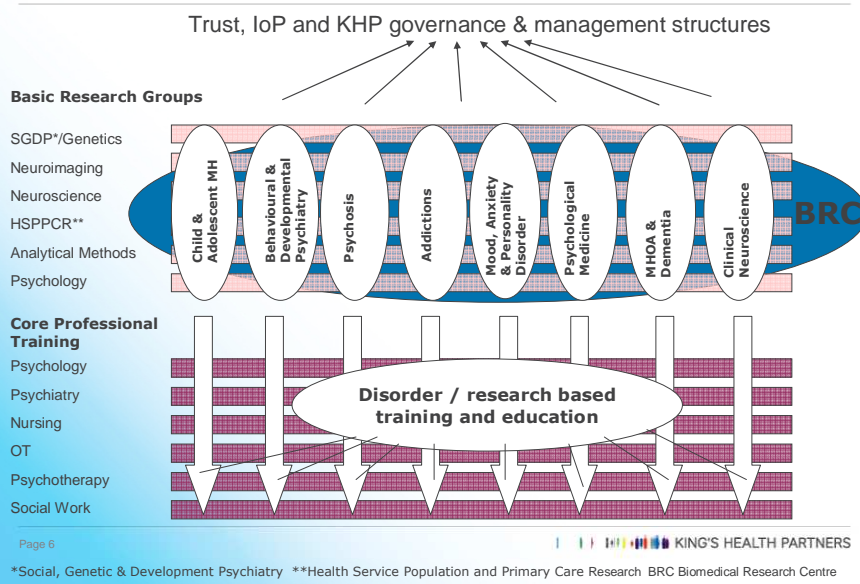
### **15) Summary of key points:**

- Kings Health Partners consulted on its Strategy during the summer of 2009
- Early discussions about CAG development focused on bringing senior staff from SLaM and IoP together and a number of guiding principles were developed
- A number of engagement workshops took place over the autumn so that staff, users, carers and their representatives, and PCT and local authority commissioners were involved in discussions about the developments
- SLaM/IoP are aligning their managerial structures to reflect CAG arrangements
- Care pathway development is a cornerstone of CAG development and it has been agreed that the first articulation of the CAG care pathways should be available by April 2010

- There will be a very inclusive approach to care pathway development as this is an important way to involve a wide range of stakeholders in a practical way

Tracey Power (tracey.power@slam.nhs.uk)  
February 2010

### Mental Health & Neuroscience in KHP:



### Mental Health Clinical Academic Groups:

Updated 7<sup>th</sup> August at SLAM Strategy Executive (Neuroscience not included)

Clinical Academic Group	SLAM Clinical Services	IoP Research
<b>Mental Health of Older Adults and Dementia</b>	MHOA Inpatient and Community Services	Part Psychological Medicine, part HSPR, and others (IOP) BRC Dementia & related disorders
<b>Children and Adolescent Mental Health</b>	Child & Adolescent Mental Health Services. Inpatient and Community based.	Child Psychiatry (IOP) BRC Mental disorders starting in childhood
<b>Addictions</b>	Inpatient and Community Addiction Services	Part Psychological Medicine – Addiction Sections. (IOP)
<b>Psychosis</b>	Early Intervention, Assertive outreach Teams, OASIS and PICKUP, Community Forensic Teams, Recovery and Support/Continuing Care teams, in-patient units (First episode, Rehabilitation, National Psychosis Unit, selected General Adult Inpatient Units and PICUs).	Part Psychological Medicine, part HSPR, part Psychology, part Forensics (IOP) BRC Psychosis
<b>Behavioural &amp; Developmental Psychiatry</b>	Mental Health Learning Disabilities services, BDU, MIETS, ALD, ADHD and ASD Clinics. Low and Medium Secure Inpatient Forensic Units. Prison Offender services.	Part Psychological Medicine, part Forensics (IOP) BRC Persistent antisocial & aggressive behaviour
<b>Mood, Anxiety &amp; Personality Disorders</b>	IAPT, Borough Psychology/Psychotherapy services, Affective Disorders Unit, Affective Disorder Rehabilitation Unit, borough Assessment & Treatment services, Crisis Recovery Unit, Centre for Anxiety Disorders and Trauma, Cawley Centre, Traumatic Stress Service, Maudsley Psychotherapy Services.	Part Psychological Medicine, Part Psychology (IOP) BRC Common mental illness
<b>Psychological Medicine</b>	General Hospital Psychiatry and Assessment services (Triage Ward/Clinical Decision units), Psychiatric Liaison Teams and crisis resolution/Home Treatment Teams. Chronic Fatigue Service. Sexual Dysfunction Service. Mother and Baby Unit. Perinatal services. Eating Disorders. HIV services.	Part Psychological Medicine (IOP) BRC Common mental illness

Page 8 KING'S HEALTH PARTNERS

# Mental Health Clinical Academic Groups

Clinical Academic Group (CAG)	To include the following South London and Maudsley NHS Foundation Trust clinical services...	To include the following Departments at the Institute of Psychiatry, King's College London*...	Relates to the following Biomedical Research Centre themes**...
Addictions	Addictions inpatient and community services	Addictions	Substance use disorders
Behavioural & Developmental Psychiatry	Mental Health Learning Disabilities services Behavioural Disorders Unit Mental Impairment Evaluation and Treatment Services Adults with Learning Disabilities Attention Deficit and Hyperactivity Disorder ASD Clinics Low and Medium Secure Inpatient Forensic Units Prison Offender services	Behavioural and Developmental	Persistent antisocial and aggressive behaviour
Children and Adolescent Mental Health Services (CAMHS)	CAMHS inpatient, outpatient and community services	Child and Adolescent Psychiatry, with elements of Social, Genetic and Developmental Psychiatry Research Centre (SGDP)	Mental disorders that start in childhood
Mental Health of Older Adults (MHOA) and Dementia	MHOA inpatient and community services	Old Age Psychiatry, with elements of Health Service Population and Primary Care Research Research (HSPR)	Dementia and related syndromes
Mood, Anxiety & Personality Disorders	Improving Access to Psychological Therapy Borough Psychology/Psychotherapy services Affective Disorders Unit Borough Assessment and Treatment services Crisis Recovery Unit Centre for Anxiety Disorders and Trauma Cawley Centre, Traumatic Stress Service Maudsley Psychotherapy Services Anxiety Disorders Residential unit	Membership drawn from Psychology, Psychological Medicine and Social, Genetic and Developmental Psychiatry Research Centre	Common mental and somatic disorders
Psychological Medicine	General Hospital Psychiatry and Assessment services (Triage Ward/Clinical Decision Unit) Psychiatric Liaison Teams Crisis Resolution/Home Treatment Teams Chronic Fatigue Service Sexual Dysfunction Service Mother and Baby Unit Perinatal services Eating Disorders CASCAID (4 Borough HIV team)	Psychological Medicine	Common mental and somatic disorders
Psychosis	Early Intervention Assertive Outreach Outreach and Support in South London (OASIS) Psychological Interventions Service for Outpatients with Psychosis (PICuP) Community Forensic teams Recovery and Support/Continuing Care teams Inpatient units: First Episode, Rehabilitation, National Psychosis Unit, selected General Adult Inpatient Units and Psychiatric Intensive Care Units	Psychosis, with elements of Psychology and Health Service Population and Primary Care Research Research	Psychosis: risk factors and mediators of outcome
<b>There will also be a Neurosciences CAG across King's Health Partners that will include the following SLaM clinical services and research activity:</b>			
Clinical Neurosciences	Neuropsychiatry brain injuries inpatients - Lishman Unit Brain injuries outpatients Neuropsychiatry outpatients Neuropsychiatry and memory disorders	Clinical Neurosciences	Clinical Neurosciences

\* In addition to these Departmental relationships, there will be other opportunities for academics to become involved in the work of CAGs. The Institute's Basic Research Departments (Neurosciences, Neuroimaging, Psychology, SGDP, HSPR) will provide support across all CAGs.

\*\*The National Institute for Health Research Biomedical Research Centre (BRC) for Mental Health is a partnership between SLaM and the IoP KCL. The BRC's research covers seven core 'disorder' specific themes (based around mental health problems and related conditions) and three 'cross-cutting' themes where research is conducted that is relevant to and linked across the whole BRC.

## Frequently Asked Questions (FAQs) – Clinical Academic Groups

Updated November 2009

The aim of this FAQ document is to try and collect, in one place, answers to the main questions and concerns that people have raised about Clinical Academic Groups. This version of the FAQ has been updated following the staff engagement workshops which took place in November, involving about 600 staff. This version also picks up on some of the issues raised by service users at a Partnership Time Event we held on 19<sup>th</sup> November.

Rather than answering each specific questions, we have tried to groups the issues raised by people into broad themes. We will keep updating this FAQ over the coming weeks and months.

### What are Clinical Academic Groups?

Clinical Academic Groups are new structures which will bring clinical services and academic activities together within a series of single managerial units.

### Why are we talking about them now?

The creation of Clinical Academic Groups underpins King's Health Partners – the Academic Health Sciences Centre (AHSC) we have established with King's College London, Guy's and St Thomas' and King's College Hospitals NHS Foundation Trusts. AHSCs are essentially a way of working together across traditional organisational boundaries to integrate research, education, training and care. Our overall ambition at King's Health Partners is to provide high quality, innovative services.

### Why are they being established?

Clinical Academic Groups are a way of bringing people together to deliver the King's Health Partners tripartite mission – excellence in clinical care, research and education. They bring together services and academic activity, clinical and academic staff, into an operational unit that can manage and deliver the AHSC agenda.

Introducing this model will enable us to align our clinical services, research and training much more closely for the benefit of patient care. It will take the unique partnership between SLaM and the Institute of Psychiatry, King's College London to another level so that we can translate high quality research into practice more reliably, consistently and systematically across everything we do.

### What does the creation of Clinical Academic Groups mean at South London and Maudsley NHS Foundation Trust (SLaM)?

Detailed discussions have been taking place across the Trust and Institute over the last few months about how and when to introduce mental health Clinical Academic Groups. The SLaM Board of Directors agreed in October that we should implement the new structures by April 2010, which will involve changes to some of the Trust's existing directorate management structures.

At the moment, most of our clinical services at SLaM are organised geographically. We will be establishing the following Clinical Academic Groups involving mental health services, teaching and research:

- Addictions
- Child and Adolescent Mental Health

- Developmental and Behavioural Medicine
- Mental Health of Older Adults and Dementia
- Mood, Anxiety and Personality Disorder
- Psychological Medicine
- Psychosis

These are described as ‘mental health CAGs’ as a shorthand way of distinguishing between them and the acute Clinical Academic Groups being established elsewhere within King’s Health Partners.

There will also be a Clinical Neurosciences Clinical Academic Group which will bring together services and research provided by both us and our acute partners.

### **Won’t naming CAGs on the basis of diagnosis increase stigma?**

We know that some people are concerned about this. Our services will continue to focus on need as well as diagnosis. As part of the process of establishing Clinical Academic Groups over the next few months we will be reviewing the names of each of them.

### **How will mental health Clinical Academic Groups actually work?**

Our aim is to provide more specialist services and more focused interventions. We have been discussing for some time the need to improve consistency and have greater clarification about what we are providing and for whom. Care pathway development is an important cornerstone for Clinical Academic Group development.

Other key themes include promoting the integration of physical, psychological and social care, the emphasis on recovery and the interface between acute and mental health services. Our Clinical Academic Groups will be based on a multi-disciplinary approach to care and treatment. Finally, and crucially, Clinical Academic Groups will empower teams to be innovative. One of the ways we will achieve this is through the development of Service Line Management at SLAM where teams have detailed information about the services they are providing, how effective they are and how much they cost.

### **What about people with complex needs who don’t fit neatly into one CAG?**

Creating Clinical Academic Groups is about how we organise and manage our services, research and education and training. It isn’t about restricting access to services or making it more difficult to move between different services.

Many people have mixed needs and will need to receive services across different Clinical Academic Groups. We need to make sure that this happens as smoothly as possible. In order to help us do this, we are developing ‘care pathways’ across all of our services. This involves developing a clear and through description of every stage that is involved in receiving care and treatment at SLAM. This will make it easier for people to understand what they can expect from our services, what happens next and what treatment options are available to them. And it means that there will be a clear process for moving between different services and different Clinical Academic Groups if that is what someone needs.

### **Will there be a formal consultation about the establishment of CAGs?**

Over the last year, there have been many discussions about the establishment of King’s Health Partners (KHP) and the central role of Clinical Academic Groups in delivering the aims of the partnership. Over the summer, people were invited to contribute to the development of the KHP Strategy during a three month consultation process. All the

comments received have been incorporated into the revised documents and these will provide the framework for the development of Clinical Academic Groups.

At this stage, establishing Clinical Academic Groups involves internal changes to the way we organise the management of clinical services and academic activity, so it isn't something that will necessarily be visible to staff or service users. That said, it is important to make sure that staff, service users and other stakeholders are heavily involved and that they have an opportunity to shape our plans. Senior staff across SLaM and the Institute of Psychiatry have been involved in detailed discussions about Clinical Academic Groups for the last few months.

A series of staff engagement workshops were held in November to give staff across both organisations an opportunity to hear more, have their say and raise questions and concerns. Just under 600 staff came along to the 6 workshops, and we have revised this FAQ on the basis of the issues that came up. We will also be repeating the exercise in the coming months, with a few changes in response to the feedback that we received from people who took part.

We also held a Partnership Time Event for service users in November which was attended by about 50 people. One of the issues which people raised was the need to produce clear information about what Clinical Academic Groups will actually mean for service users, and this is something we will do.

An event for our local commissioners is taking place in December.

Looking further down the line, the work we are doing on care pathways may lead to proposals on how we might change some of our clinical services. If this is the case, then the standard process for consulting with people will be used as appropriate.

### **What does the introduction of mental health CAGs mean for the Institute of Psychiatry, King's College London?**

A partial reorganisation of departments at the Institute of Psychiatry took place earlier this year to create a series of smaller units aligned to Clinical Academic Groups. This involved rearranging the existing Division of Psychological Medicine and Psychiatry, and the Department of Forensic Mental Health were established in the following areas:

- Addictions
- Developmental and Behavioural Disorders
- Imaging
- Old Age Psychiatry
- Psychological Medicine
- Psychosis

The Institute will also maintain Basic Research Groups – focussed areas of scientific expertise which will cut across Clinical Academic Groups (e.g genetics [SGDP], imaging neurosciences, health service and population research, and psychology services).

### **How will staff be affected by this change?**

These changes are about how we manage clinical services within SLaM and clinical research at the Institute of Psychiatry for maximum patient benefit. We hope they will provide a means to help us to respond effectively to the funding pressures across the public sector by focusing on quality and service improvement. Front line clinical and

academic staff are unlikely to experience much direct impact upon their roles in the short-term. In the longer term, the idea behind the creation of Clinical Academic Groups is that the lessons from research will feed into clinical services more effectively and quickly.

### **Why haven't Clinical Academic Groups been set up before now?**

Since the end of the old asylums, the development of mental health clinical services has been driven by the need to assemble a new set of services – home treatment, inpatient units, community mental health services etc. We are coming to the end of that phase, and the focus needs to shift more towards how we can ensure that each of these service components works together to deliver the most benefit to service users. The development of Clinical Academic Groups isn't about replacing the system of care we have established over the last ten years, it is about refining, improving and developing it.

### **How will we retain our borough based partnerships with local authorities and Primary Care Trusts (PCTs)?**

The development of Clinical Academic Groups will mean developing alternative internal management structures that better reflect our intention to provide more focused and specialist services for people with specific diagnoses and needs. At the same time, we will continue providing services suited to local communities building on arrangements with boroughs developed in the ten years since SLAM was established.

Our partnership with local authorities and PCTs is still fundamentally important to the way we provide clinical services. There will remain clear lines of accountability, back ultimately to funders, for different budgets which are managed within Clinical Academic Groups, and also for their performance against their contractual, quality and regulatory obligations. This is a change to the way the clinical services at SLAM and academic research at the Institute are organised now but we hope that applying the changes will address some of the current shortcomings in the current arrangements.

### **Who will be in charge of the Clinical Academic Groups at SLAM?**

Ultimately, the SLAM Board of Directors remains responsible for the clinical services managed within SLAM. The Institute of Psychiatry's Management Board remains responsible for academic research. Each Clinical Academic Group will also report to the King's Health Partners Partnership Board and Executive team for delivery against the KHP strategic objectives.

### **Where do decisions get made about CAGs?**

At SLAM, the Board of Directors is responsible for making the final decision on issues about how our clinical services are managed, based on recommendations from the Trust Executive. And, as highlighted above, the Institute of Psychiatry's Management Board remains responsible for academic research. A mental health Clinical Academic Group steering group is responsible for co-ordinating the operational detail. This group is chaired by SLAM's Medical Director Dr Martin Baggaley and includes senior representatives from both SLAM and the IoP.

The ultimate authority within King's Health Partners AHSC is the Partnership Board, which includes SLAM's Chair Madeliene Long and Chief Executive Stuart Bell.

### **What happens next?**

Detailed planning is underway to establish mental health Clinical Academic Group managerial structures by April 2010. This process will include the following steps:

- The reconfiguration of adult mental health management teams to match the Psychosis, Psychological Medicine and Mood, Anxiety and Personality Disorder CAGs and the establishment of Clinical Academic Group leadership.
- A programme for the development of high level care pathways within each Clinical Academic Group and across the Trust.

In the long term, as Clinical Academic Groups are accredited by King's Health Partners Academic Health Sciences Centre, these will bring together clinical, managerial and academic leadership. In the short term, prior to accreditation, academic leadership will remain separate in the linked IoP department, but working very closely alongside the relevant clinical services. Some service leadership changes will however be required in the short term to reflect the realignment of services, and so appropriate appointments processes will be required. The formal Clinical Academic Group accreditation process will take place across King's Health Partners Academic Health Sciences Centre during 2010/11.

Accountability, budgetary and performance management processes will need to be adjusted to reflect Clinical Academic Group structures. Contractual relationships with commissioners and other relationships with stakeholders will need to be reviewed, and it will be essential to set out how existing strong links to borough and PCT boundaries will be managed in the new arrangements.

## Framework for CAG Care Pathway Development

November 2009

***“Care pathways are both a tool and a concept that embed guidelines, protocols and locally agreed, evidenced-based practice, into everyday practice for the individual patient” (NHS Protocols & Care Pathways Library)***

Overall aim of the CAG is to provide high quality, innovative services by effectively integrating clinical and academic activity. Care pathways can serve as a useful tool to reduce unacceptable variations in service provision and improve quality (e.g. reduce LoS or multiple assessments, improving multi-disciplinary collaboration, increasing evidence based practice, providing a strategic approach to cost efficiency, enhancing user empowerment and putting recovery & social inclusion principles at the heart of services) but only if they are actually implemented. Successful implementation depends on the direct involvement and investment of key stakeholders and substantial clinical engagement is essential.

### **Strategic context**

An early priority for CAGs is the development of a strategy to deliver the KHP tripartite mission. This needs to reflect national priorities (e.g. New Horizons, QUIPP) and local ones (KHP and SLaM). A key driver for all of the public sector is the likelihood of a funding reduction of about 20% over the next 5 years. This will drive business planning priorities.

### **Guiding principles**

Early discussions about CAG development generated a set of principles or “terms of engagement” for CAG development:

- Improving the quality of services & increasing user satisfaction
- Providing more specialist services & more focused interventions
- Integrating physical, psychological & social approaches
- Enhancing multi-disciplinary approaches
- Empowering teams to innovate
- Promoting partnerships with stakeholders

It is expected that the care pathway development process should reflect these principles. In particular it is expected that there will be a significant focus on a holistic approach that integrates health and social care interventions and promotes recovery and social inclusion

### **Learning from what has been done already**

There is a significant amount of information available about how others have approached care pathway development and indeed there are examples within

SLaM. The references below are a “resource pack” for each CAG to support the local processes.

### **Identifying the processes will work best in SLaM**

Although it is important to make use of the lessons learned elsewhere, it is also crucial to develop a local process based on engaging a wide range of stakeholders. Frontline staff and service users will be very motivated to contribute to this process and it is important to identify the best way to involve our commissioners.

### **Using Lean methodology**

It is proven methodology to identify value and eliminate waste. It encourages and supports workforce and service redesign and emphasises the involvement of stakeholders. It can be achieved by taking people out for short intense periods of time supported by trained facilitators. There are “experts” within SLaM who can support this process.

### **Making the best use of the supports**

In addition to clinical and academic champions and those who have already been involved in care pathway development, there are also NICE Guidance leads who can provide support for this process. The Service Improvement leads can help access support for practical arrangements (e.g. workshops) as well as providing expert Lean advice. It is important to identify the range of individuals who can provide support for this process and to co-ordinate this via the CAG development process.

### **Supporting CAGs to work with each other, and with other organisations**

Many service users have complex needs and it will be necessary to allow individuals to change between pathways relatively easily, and if necessary to receive treatment and care along more than one pathway. Care pathways will cross CAG boundaries and the development process needs to take into account the myriad interfaces between services. Care pathways provide the opportunity to be explicit about the interfaces between services and indeed organisations so it is crucial that these developments do not take place in silos.

### **An appropriate level of standardisation**

It is important to balance a top down and bottom up approach. CAGs need to deliver the “must do’s” in relation to compliance and target requirements and this needs to be seen in the context of our approaches to quality enhancement. They need to support the implementation of PbR and SLM. Care pathway development needs to incorporate these requirements and operational procedures need to reflect this. Further, performance measures must demonstrate delivery. So care pathways must be based on needs based profiles/clusters using standardised needs assessment tools (e.g. HoNOS). There must be an appropriate set of quality and outcome indicators for the care packages. The aims, interventions and activity described in the care pathways must be in line with best practice (e.g. NICE). Therefore there needs to be a common framework for care pathway development but with sufficient flexibility so that there is local ownership.

### **Addressing the realities of the financial environment**

We need to ensure that the organisation can cast a “critical eye” on the process so that there is an appropriate focus on increasing productivity and delivering efficiencies. This process is not just about describing what we do now, it is about an opportunity to redesign and transform services and make better use of our resources. This is crucial within the financial environment and we need to be honest about the need to do this.

### **Timeframes and priorities**

It has been agreed that the first articulation of the CAG care pathways should be available by April 2010 although this will clearly be work in progress. It is acknowledged that many of the pathways may be quite high level in the first iteration and there will much further work undertaken to refine and robustly implement them.

### **Systematic review and evaluation**

We need to make sure that the process supports service redesign in a systematic way. We need to ensure that this is not a one off process but a cycle of continuous review and development. Where there has already been progress made in care pathway development, we need to ensure that this is reviewed in the light of our current and future ambitions.

### **Timeframe for care pathway development**

The key tasks include:

- Developing the high level pathways by April 2010 which set out a consensus of what might be considered an “ideal” pathway by key stakeholders
- Auditing and reviewing current practice and provision against the desired pathways (by autumn 2010)
- Development of new service models with associated changes in workforce (informing business planning priorities)
- Negotiation with commissioners about standard and enhanced pathways and how these are translated into service specifications and contracts (to inform contract for 2011/12)
- Development of a process to formally sign off pathways at a Trust level
- Developing ePJS to support the ongoing monitoring and evaluation of the implementation of the pathways (incrementally during 2010/11)

## List of Resources for Developing Care Pathways

The following references provide information about approaches to the development of care pathways.

### **Clinical pathways in psychiatry**

Evans-Lacko, Jarrett, McCrone & Thornicroft. British Journal of Psychiatry (2008) 192, 1-2. doi: 10.1192/bjp.bp.107.048926  
Summary of literature on the use of care pathways in psychiatry.

### **Welcome to the NHS QIS toolkit for Integrated Care pathways for Mental Health**

NHS framework for development of mental health care pathways.  
<http://www.icptoolkit.org/home>

### **Integrated Care Pathways in Mental Health**

By Juliet Hall and David Howard  
Practical advice on the steps required to develop mental health care pathways.

### **Developing Care Pathways: The handbook – [Vol.2]: The toolkit**

By Kathryn De Luc, Denise Kitchiner, National Pathways Association  
The book is in two parts. A handbook that defines and describes the care pathway and the roles of health care professionals involved in them and a tool kit which provides a systematic guide to developing care pathways.

### **NHS London Mental Health Clinical Care Pathway Group working report.**

This document is the working report of the Mental Health Clinical Care Pathway Group commissioned by NHS London as part of the Darzi review. The report summarises work completed during November 2007 and January 2008. Available from Ann Watts.

### **Electronic Pathway**

Map of Medicine Health guides is a web-based visual representation of evidence-based patient care journeys covering 28 medical specialities and over 340 pathways. Pathway information is available electronically and they are considering developing a local view pathway on Map of Medicine. This is only in the very early stages of development and current the pathways are at a national level but it would be possible to add local information such as local contact details and local signposting information.

Click the link below for the pathway for suspected schizophrenia (first episode):

<http://healthguides.mapofmedicine.com/choices/map/schizophrenia1.html>

Click the link below for the bipolar disorder pathway:

[http://healthguides.mapofmedicine.com/choices/map/bipolar\\_disorder1.html](http://healthguides.mapofmedicine.com/choices/map/bipolar_disorder1.html)

### **Offender mental health care pathway**

This care pathway document lays down valuable best practice templates to guide providers and commissioners on mental health service for those involved in the criminal justice system. It is based on the best evidence currently available, sourced from both literature and innovative clinical practice.

[http://www.nhis.info/nhis\\_resources/DMenHealthPrisonPathway.pdf](http://www.nhis.info/nhis_resources/DMenHealthPrisonPathway.pdf)

### **Cambridgeshire and Peterborough NHS Foundation Trust**

The specialist website from Cambridgeshire and Peterborough NHS Foundation Trust for GPs, commissioners, referrers and clinicians has a section on their approach to mental health care pathways.

<http://www.clinicom.cpft.nhs.uk/Carepathways/tabid/246/Default.aspx>

Copies of their pathways can be obtained from Ann Watts:

[ann.watts@slam.nhs.uk](mailto:ann.watts@slam.nhs.uk)

### **Lancashire NHS Care Pathways**

Includes protocols, flow charts, process maps and interventions.

<http://www.lancashirecare.nhs.uk/care-pathways.php>

### **Cornwall Shared Care Pathway for People with Dementia**

A pioneering dementia care pathway developed in Cornwall. This care pathway has now been reviewed and further information can be found from the links below.

<http://cat.csip.org.uk/library/A%20shared%20care%20pathway.pdf>

### **Integrated Care Pathways: A Handbook for Occupational Therapists (published 18<sup>th</sup> September 2009)**

This is a pan London collaborative project which has developed a series of 8 high level mental health OT pathways. SLaM was very much involved and our Head/lead OTs hope to integrate these into the CAG Care Pathways. Available from Gabrielle Richards and other Head/Lead OTs.

### **SLaM Addictions Care Pathways**

SLaM Addictions Division has produced a document in two sections setting out elements of practice common to all Addiction patients and substance specific pathways for each substance (divided into treatment outline, treatment options, protocols and patient information). It is available on the SLaM Addictions Intranet site.

### **Lambeth Psychosis care pathway**

NHS Lambeth and South London and Maudsley NHS Foundation Trust are working together with social services, GP practices, primary care, voluntary agencies, service users and carers to try to improve the help and support that people experiencing psychoses, and those close to them, receive. The project is funded by Guy's and St Thomas' Charity and South London and Maudsley Trustees and it is hoped that this new way of working, the integrated care pathway approach, will put the client at the centre of the service in order to improve their experience and promote choice.

[Http://www.lambethpct.nhs.uk/a/985](http://www.lambethpct.nhs.uk/a/985)

**SLaM Southwark inpatient care pathway for acute admission wards and Psychiatric Intensive Care.**

This is the latest inpatient care pathway updated in October 2009 from SLaM Southwark Directorate. It helps to clarify understanding of the inpatient care pathway, aims to reduce the repetitive questioning relating to a service users assessment and increase the effectiveness and smooth transition between the events in a patients care pathway. Copies can be obtained electronically from Ann Watts: [ann.watts@slam.nhs.uk](mailto:ann.watts@slam.nhs.uk)

**Care Pathways – An update**

Progress report presented to the SLaM Quality Executive in January 2008. Available from Ann Watts.

**Payment by Results (based on needs based clusters)**

There are a large number of documents on the DoH website which include quarterly fact sheets (last one published July 2009) and presentations made at the Mental Health Payment by Results Development Clinical Conference on 25<sup>th</sup> June 2009.

**Payment by Results in mental health: a review of the international literature and an economic assessment of the approach in the English NHS.** Published by the University of York Centre for Health Economics on 28<sup>th</sup> September 2009.

<http://www.york.ac.uk/inst/che/pubs>