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Registered address
Bethlem Royal Hospital,
Monks Orchard Road,
Beckenham BR3 3BX

Contact details
Switchboard
T 020 3228 6000

Patient Advice and Liaison Service (PALS)
T 0800 731 2864
E pals@slam.nhs.uk

Membership
T 0800 019 6075
E membership@slam.nhs.uk

Website
www.slam.nhs.uk

Find out about King’s Health Partners –
the Academic Health Sciences Centre
we are part of, along with King’s College
London, and Guy’s and St Thomas’ and
King’s College Hospital NHS Foundation Trusts
www.kingshealthpartners.org

Annual report
This report was produced by the Communications Department. Please contact us if you would like a
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another language.
T 020 3228 2830
E communications@slam.nhs.uk
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*Pictured Left: The London Eye, Lambeth*
About us —

Who we are

Clinical services
— Most extensive portfolio of mental health and substance misuse services in the UK, serving a local population of 1.1 million in south London and offering specialist expertise nationally.

How we measure up
— Rated ‘excellent’ for quality of services and use of resources by the Healthcare Commission in 2008 – one of 42 NHS Trusts, out of a total of 391 in England, to achieve a double rating of ‘excellent’
— Given a score of 100%, at Level 2, in an assessment by the NHS Litigation Authority (NHSLA), which looked at how well we implement policies in relation to issues such as clinical care, governance and learning from experience.

Research
— Working in partnership with the Institute of Psychiatry, King’s College London to generate and put into practice world leading research
— Largest mental health research and development portfolio in the country
— Joint host with the Institute of Psychiatry of the UK’s only specialist National Institute for Health Research (NIHR) Biomedical Research Centre for mental health.

Education and training
— Provider of an extensive range of learning opportunities, delivered in part from three hospital based training centres
— Responsible for delivering 14,000 training experiences a year, including e-learning, study days and workshops
— A leader in the field of involving service users in the provision of education and training
— Provider of the most comprehensive mental health NHS library in London.

Partnership
— Part of an Academic Health Sciences Centre (AHSC) – King’s Health Partners – which promotes health in mind and body, and which is one of only five AHSCs in the U.K
— Provider of integrated adult mental health and social care services in partnership with local authorities.

History
— A history that dates back to the foundation of the Bethlem Royal Hospital in 1247, the oldest psychiatric institution in the world.

Our objectives
— To treat mental illness effectively
— To work in partnership to promote mental well-being
— To support others by sharing our clinical expertise and knowledge.

Our core value
— Everything we do is to improve the experience of people using our services, and to promote mental health and well-being for all.
About us —
What we aim to do

Provide high quality clinical care and treatment, delivered sensitively, consistently and based on evidence that it works

Which means...
— Delivering local services in partnership with local authority social care teams, which meet the diverse needs of our local communities
— Developing better treatments through excellence and innovation, based on reliable and up to date evidence of what works best
— Ensuring that our inpatient services measure up against the best that is available elsewhere
— Being clear about what we offer, which includes:
  ● describing our clinical services in a way that can be understood by the people who use them and their carers
  ● defining care pathways across the whole system of care, so that commissioners and service users are clear about the stages involved in the care and treatment provided by South London and Maudsley NHS Foundation Trust (SLaM)
  ● providing clear evidence that our services are both clinically and cost efficient, delivering effective outcomes
— Systematically obtaining feedback from service users and carers about their experience of using our services – and using it to develop and improve our services
— Expanding the provision of psychological therapies across all our services.

Promote recovery, social inclusion and mental well-being

Which means...
— Moving beyond a service that mainly reacts and responds to illness, and contributing even more widely to helping the community stay well
— Providing services which are focused on recovery – as well as containing and treating the symptoms of illness – and which offer choice and promote independence
— Providing help back into education or employment for those people who want it.

Translate research into practice

Which means...
— Undertaking research which is relevant to the needs of our clinical services and local populations
— Making sure that research is applied – directly, speedily and consistently – to improve clinical care and treatment
— Ensuring that we have a well deserved reputation for excellence in research that benefits people who use our services, and helps to transform services beyond SLaM
— Ensuring that all members of the multi professional team have the opportunity to grow the research portfolio
— Making the most of our strong relationship with colleagues in King’s Health Partners to maximise the global impact of our research portfolio, enabling all partners to compete with the best in the world.
About us —
What we aim to do

Create a supportive environment which enables people to flourish and achieve excellence

Which means...
— Attracting, recruiting, developing and retaining the best staff
— Recognising that staff are talented and have the potential to learn and contribute more
— Paying attention to high quality performance and challenging poor performance
— Helping staff experience a sense of achievement and satisfaction from their work
— Encouraging new ideas and new ways of working as a means of delivering better services
— Being an organisation where people want to come and work
— Providing opportunities for people who have used mental health services to come and work here
— Striving for excellence and challenging mediocrity
— Valuing creativity and innovation.

Develop as an organisation so that quality becomes central to everything we do

Which means...
— Encouraging a ‘can do’ culture
— Embracing change
— Encouraging openness and learning from when things go wrong
— Involving teams in the organisation’s development
— Developing commercial skills so that the organisation is able to thrive in a more competitive environment.

Maintain corporate infrastructure services which provide effective, timely and customer friendly support

Which means...
— Readily accepting that the way we have done things in the past may not be the best way of doing so in future
— Ensuring that our infrastructure services are flexible, adaptable and decisive
— Being open to new ways of working, which may mean sharing resources across King’s Health Partners.

Provide leadership and management which inspires, directs and drives the organisation

Which means...
— Setting a vision and providing a clear sense of direction to all parts of the organisation – clinical services, research, education and corporate infrastructure
— Allowing people the freedom to act, make decisions and take risks where appropriate
— Providing a safe environment that enables staff to develop ideas and new ways of working, and where errors can be used constructively to promote learning.

Develop and grow as an organisation in order to respond effectively to the changing environment within which we operate

Which means...
— Understanding what people want from and think of us – by engaging with, responding to, and respecting the views of commissioners, referrers, service users, carers, the wider community and other stakeholders
— Working collaboratively with our partners in social care
— Developing the commercial and marketing expertise needed to thrive in a competitive environment and respond effectively to opportunities for growth
— Managing our resources effectively and developing financial surpluses which we can then reinvest to fund developments
— Increasing referrals because we have earned a reputation for clinical excellence.
About us —
Where we provide services

Local services
- Local mental health and substance misuse services for people living in the London Boroughs of Croydon, Lambeth, Lewisham and Southwark
  - Very high levels of mental health need, significant local forensic services, joint provision with local authorities.

Regional specialist services for SE London
- Addictions, peri-natal, mother and baby inpatient services, eating disorders.

National (and international) specialist services
- Behavioral disorders
- Specialist psychological therapies
- Neuro-psychiatry, national psychosis unit.

Boroughs where we provide mental health and substance misuse services
- Croydon
- Lambeth
- Lewisham
- Southwark

Boroughs where we provide substance misuse services
- Bexley
- Bromley
- Greenwich

Inpatient sites
- Bethlem Royal Hospital
- Ladywell unit – Lewisham Hospital

Population totals
- Inner London boroughs 3,003,300
- All Greater London 7,556,900

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About us —
Where we have come from

>Our history in brief

The Priory of St Mary of Bethlehem, Bishopsgate, was founded on land given by Alderman Simon Fitzmary. It later became a place of refuge for the sick and infirm. The names ‘Bethlem’ and ‘Bedlam’, by which it came to be known, are early variants of ‘Bethlehem’. It is first referred to as a hospital for ‘insane’ patients in 1403, after which it has a continuous history of caring for people with mental distress.

Henry Maudsley wrote to the London County Council offering to contribute £30k towards the costs of establishing a “fitly equipped hospital for mental diseases.” The Maudsley initially opened as a military hospital in 1915 to treat cases of shell shock and became a psychiatric hospital for the people of London in 1923.

Sister Lena Peat and Reginald Bowen became the first community psychiatric nurses, following up patients at home who had been discharged from Warlingham Park Hospital in Croydon.

>Yr. 1247

In 1867, the Southern Districts Hospital (or Stockwell Fever Hospital as it became known) opened on the site which is today known as Lambeth Hospital.

>Yr. 1908

With the introduction of the National Health Service in 1948, the Bethlem Royal Hospital and Maudsley Hospital were merged to form a postgraduate psychiatric teaching hospital. The Maudsley’s medical school became the Institute of Psychiatry.

>Yr. 1948

>Yr. 1954

>12/100
South London and Maudsley NHS Trust was formed – providing mental health and substance misuse services across Croydon, Lambeth, Lewisham and Southwark; substance misuse services in Bexley Greenwich and Bromley; and national specialist services for people from across the UK.

South London and Maudsley became the 50th NHS Foundation Trust in the UK under the Health and Social Care [Community Health and Standards] Act 2003.

The Ladywell Unit, located at University Hospital Lewisham, was refurbished for use by adult inpatient mental health services. The development brought together inpatient services which had previously been spread across other hospital sites (Hither Green, Guy’s and Bexley).

South London and Maudsley is part of one of the five Academic Health Sciences Centres (AHSCs) in the U.K to be accredited by the Department of Health. King’s Health Partners AHSC consists of SLaM, King’s College London, and Guy’s and St Thomas and King’s College Hospital NHS Foundation Trusts.
It seems that the media is always full of stories about one kind of anniversary or another. So you might be forgiven if news of another one had passed you by. But I think the 60th anniversary of the creation of the NHS, which took place in 2008, is worth taking note of. First and foremost, because the principle that good healthcare should be available to all, regardless of wealth, is one worth celebrating and cherishing.

I also think that you can sometimes draw inspiration for the future by looking back and reflecting upon what you’ve achieved in the past. In mental health we have certainly come a long, long way in the last six decades from a system of care that – at its worst – involved locking people away in large institutions, out of sight and mind from the rest of society.

Today, there are many exciting developments within the NHS to promote mental health and well-being.

For example, a major programme is underway to train a whole new workforce of psychological therapists. This will ensure that people with anxiety and depression across the country will have better access to talking therapy, at times and in places that are convenient to them.

The development of a national dementia strategy, led by Professor Sube Banerjee – clinical director of our mental health of older adult services – is giving real and much needed attention to a condition that affects millions of people and which has been subject to stigma and patchy service provision for far too long.

More broadly, we are working with our partners at King’s College London, Guy’s and St Thomas’ and King’s College Hospital NHS Foundation Trusts to ensure that the lessons from research are applied to clinical practice through the creation of an Academic Health Sciences Centre (AHSC). The fact that our AHSC, King’s Health Partners, has been established to promote health in body and mind is a powerful illustration of the fact that there can be no health without mental health.

Of course, nobody would claim for a minute that there aren’t things that could and should be much better about our healthcare system. At the same time, all of us know someone who has a positive story to tell about the care that they or those close to them have received from the NHS. Wherever you go within the NHS – I certainly see it all the time at SLaM – you will meet staff who feel passionate about the importance of delivering the best possible service to patients.

In 2009 we come to the 10th anniversary of the creation of South London and Maudsley. I am proud to be part of an organisation which is one of 42 NHS trusts, out of a total of 391 in England, to receive a double rating of ‘excellent’ for quality of services and use of resources in the Healthcare Commission’s annual assessment of health service performance. This rating is the result of hard work and commitment from staff across the organisation, and I would like to thank you for your efforts.

I would also like to highlight the achievement of Stuart Bell, SLaM’s Chief Executive, in being awarded a CBE in the Queen’s 2008 birthday honours list. This was a well deserved personal achievement for Stuart and a great recognition of his contribution to the work of SLaM.
This year we celebrated the tenth anniversary of the creation of South London and Maudsley. While this is a relatively short time in an organisation that can trace its history back to the founding ofBethlem Royal Hospital in 1247, it does provide a timely opportunity to reflect upon our achievements.

A great deal of change has happened in the last 10 years. We are providing care to people closer to home, identifying and treating illness earlier and working much more closely with local partners in health and social care. Our focus has increasingly shifted towards promoting well-being and recovery, at the same time as providing effective intervention in illness. We have launched new services such as home treatment teams, and made many improvements to the quality of our inpatient services and environment.

There are a number of examples of how our research has had a major impact upon national policy development, recent examples being the national strategies for dementia and psychological therapies. In partnership with the Institute of Psychiatry, King’s College London we now manage the UK’s only specialist National Institute for Health Research (NIHR) Biomedical Research Centre for mental health, providing a real opportunity to ensure that lessons from research feed directly into patient care.

Conversely, the most significant financial issue for the Trust over the last year has been the loss of research and development (R&D) income as a result of national changes to the way this funding is allocated. We have worked closely with our four main commissioners to manage the impact of this, and we have been involved in productive discussions with the Department of Health about the cost of conducting mental health research.

In terms of the Trust’s overall financial position, we reported a net deficit of £6.7m. This was the result of two related factors: firstly, a reduction in the value of the Trust’s land and building assets due to downward changes in the broader economic climate; secondly, capital expenditure on building works (including the conversion of office space into a new inpatient ward at Lambeth Hospital) which, while necessary to deliver the estates strategy did not necessarily increase the value of those assets. The impact on the income and expenditure account and resulting deficit that arose from these two issues have not affected the provision of clinical services. The Board of Directors is confident that the Trust’s underlying financial position remains sound.

We have achieved much in the last year, not least the ‘excellent’ rating we received from the Healthcare Commission (now the Care Quality Commission) for both quality of services and use of resources in its most recent independent review of our performance.

Looking to the future, we are part of an Academic Health Sciences Centre (AHSC) with King’s College London, Guy’s and St Thomas’ and King’s Healthcare NHS Foundation Trusts. One of the principles which underpins the idea of a successful AHSC is that the best healthcare research in the world is of limited value unless you are actually able to put it into practice for the benefit of patients.

— Stuart Bell CBE, Chief Executive
Message from the Chief Executive

Being part of King’s Health Partners AHSC will, in the long-term, enable us to attract and retain the highest calibre staff and to secure research funding to support the development of innovative clinical services of the highest quality. Working more closely with medical colleagues within the acute sector gives us the potential to develop innovative services which consider both the physical and psychological aspects of health.

The building blocks of King’s Health Partners are Clinical Academic Groups. These are new structures which will bring together clinical services and academic activities within a series of single managerial units. 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 to another level so that we can translate high quality research into practice more reliably, consistently and systematically across everything we do.

South London and Maudsley is an organisation with a rich history. Being part of one of only five AHSCs in the UK means that we have an exciting opportunity to shape the future provision of healthcare in the UK and beyond.
In focus —

Innovative clinical service developments, groundbreaking research, shaping national policy, developing new ways to help people on their journey towards recovery – all of this takes place at South London and Maudsley NHS Foundation Trust. Here are just a few examples from the last year, including the perspective of some of the people who have used our services...
In focus —

Animated response to OCD

A teenager who used our national service for young people with Obsessive Compulsive Disorder (OCD) has helped to create an animated film about his experiences.

— says Danny

“"I’m better because of having help at the Maudsley.””

OCD is a form of anxiety disorder in which an individual experiences recurrent, intrusive thoughts or obsessions. These cause anxiety and are usually accompanied by compulsions such as washing or checking which, when severe, can take hours to complete each day and cause a lot of distress.

17 year-old Danny narrates the film which focuses on the frustrations and challenges of having OCD.

“I thought I would do it to help get the message across to more people so they can get help if they need to,” says Danny. “I’m better because of having help at the Maudsley. I had cognitive behavioural therapy. We looked at my OCD as a whole and then broke it down into its separate rituals and targeted each ritual one at a time. Having OCD doesn’t affect me so much now and it’s getting easier all the time.”

Dr. Georgina Krebs, clinical psychologist and Danny's therapist, says: “It is brilliant that Danny made this cartoon because it will help other people with OCD realise that they are not alone. Danny has made an excellent recovery from his OCD and is an inspiration to others.”

You can view the film at www.teachers.tv/video/29884
In focus —

Treating the ‘untreatable’

Research piloting the use of the UK’s first supervised injection clinics for treatment resistant heroin users has been showing highly positive results that are restoring lives, informing national policy and revolutionising clinical practice.

The Randomised Injectable Opioid Treatment Trial (RIOTT) has piloted the use of injectable diamorphine and methadone under medical supervision at three clinics – in South London, Brighton and Darlington.

The programme targets a minority of people who have experienced years of drug dependency and who have proved difficult to treat. The social costs of heroin addiction are many times greater than the cost of treatment in this hard to treat group. Many lead chaotic lives and may become involved in crime to buy illicit heroin. There is also the cost to the benefits system, the loss of economic productivity and the wider effect on families.

The research trial is run by the National Addictions Centre (NAC), which is jointly managed by SLaM and the Institute of Psychiatry, King’s College London. By managing drug dependence in a medical environment, clinicians are able to ensure that people continue to receive the kind of psychological, physical health and social care support that are essential in helping someone recover from addiction.

“As a clinician in this field for 25 years, I have been greatly struck by the enormous improvements in these patients. These are people who until now have tried – and failed – time and again to stay in treatment. Now we are seeing positive progress,” says, NAC director Professor John Strang.

Peter McDermott from the national expert group evaluating RIOTT reported on service users’ views: “Participation was not seen as an easy option, and many knew people who had refused a place on the programme because of the high level of commitment required. All reported dramatic improvements in their health and well-being, reduced offending and improved quality of life.”

The Government’s 10 year National Drugs Strategy, published in 2008, includes a commitment to roll out this model of treatment if the NAC’s research shows that it works.

RIOTT arose from academic surveillance of studies around the world, notably in Holland, Switzerland and Germany. It was the first trial of its kind in England and the work of the early pilots will now be extended to other sites around the country. UK expertise is already being shared with colleagues in Denmark and it is hoped that this can be extended to other countries.
Three years ago Godfried was admitted to Lambeth Hospital. “I was taken to hospital suffering from schizophrenia. I was living with my partner and working really long hours. I started smoking cannabis to relax and things began to get out of control. I was in hospital for about a month and when I came out, I’d lost the passion I had for life.”

Godfried tried his hand at many things “As I began to feel a bit better I tried a course in interior design and another in health and social care. Neither of them were for me, but then I thought, ‘I want to cook’. My key worker helped me find a placement at Abbevilles Restaurant in Clapham.”

Abbevilles is operated by First Step Trust (FST) in partnership with SLaM. FST provide work placements where people can build up their work experience, gain skills and qualifications and get support in finding a job.

The restaurant is open to the public at lunchtimes serving modern European food as well as take-away sandwiches and has a catering service for conferences and events.

“Since I’ve started working at Abbevilles I’ve also been going to College to do a catering course. I’m enjoying every bit about it.”

Godfried continues to receive support from his clinical team. “SLaM has been very good to me, I’ve no complaints. Every time I need help I talk to my key worker and she gives me great advice. I feel like I’m finally on the right road. My main goal is to open a restaurant of my own one day.”

“I look forward to coming to work. When I’m at home, I’m thinking about being at work and cooking. When my friends come over I cook for them. I’m getting a bit of a reputation.”
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In focus — Living well with dementia

Services for people with dementia have come under the spotlight in the last year with the publication of a five–year National Dementia Strategy, co–written by Professor Sube Banerjee, SLaM’s clinical director with responsibility for the mental health of older adults.

While there is, as yet, no cure for dementia, Professor Banerjee stresses that much can be done to make a positive impact on people’s quality of life. To start with, an accurate diagnosis gives power to people with dementia and their carers.

"Without it they cannot access treatments that are of benefit, and with it they can plan for the future and make choices for themselves that can prevent harm and promote good quality of life in the seven to 12 years that they may live with the illness," he says.

"Ignorance of diagnosis is not bliss for the very large majority of people with dementia and their carers – ignorance is confusion, distress, and despair. The National Dementia Strategy will enable this to change using lessons learnt from SLaM’s Croydon Memory Service."

The award-winning Croydon service provides early assessment, diagnosis and comprehensive support ‘under one roof’ in partnership with local Social Services and the Alzheimer’s Society.

The Department of Health wants to see services like Croydon’s becoming the norm across England. Its strategy, which is underpinned by an extra £150 million over the next two years, highlights the fact that just one person in three with dementia currently receives an accurate diagnosis. And this diagnosis tends to take place late in the illness, in crisis, when prevention of harm is no longer possible. In Croydon, the figure for diagnosis has trebled in the last three years to at least two thirds. On average, referrals are followed up within three to four weeks, and clients receive a diagnosis within six to eight weeks.

There are around 700,000 people in the UK with dementia, costing the nation £17 billion annually – and this is predicted to increase in 30 years to 1.4 million and £50 billion respectively.

The national strategy has three themes: to improve public and professional awareness of dementia; to enable early diagnosis and intervention for all; and to improve the quality of care provided to people with dementia and their carers from diagnosis right through to the end of life.
Now we’re talking: improving access to psychological therapy

SLaM is at the forefront of introducing major changes to the way ‘talking therapies’ are provided in England.

A national strategy is now in place to create an entirely new workforce to help people with common conditions such as depression and anxiety. A key figure behind this is David Clark, professor of psychology at the Institute of Psychiatry, King’s College London and director of the Maudsley Hospital’s Centre for Anxiety Disorders and Trauma. On a national stage, he is the national director of Improving Access to Psychological Therapies (IAPT) strategy.

“Over the next three years, the government is committed to training at least 3,600 people to become psychological therapists and to deploy them in new treatment services for people with anxiety disorders and depression,” he explains. “A radical aspect of this strategy is that it overturns 60 years of tradition in the NHS, where GPs have traditionally been the gatekeeper to specialist services, whereas IAPT services will also accept self-referrals.”

Those who don’t recover will be ‘stepped up’ to receive more time intensive, one-to-one treatment with a fully qualified therapist. This twin-track approach is underpinned by a new training strategy; 60 per cent of the workforce will be ‘high intensity’ therapists, while the remainder will be ‘low intensity’ workers who will see those with less intractable conditions.

Those recruited to the first group generally have generally worked in the mental health field and have prior training in delivering psychological therapies – they might be recent clinical psychology or counselling psychology graduates, nurse therapists or primary care counsellors, for example. While those in the second group are also graduates, they generally have no formal training in a mental health profession.

Professor Clark stresses that certain individuals will be fast-tracked on to see professionals who can provide ‘trauma focused’ CBT. They might, for example, be suffering from distressing memories after being mugged or being in a road traffic accident, or have emotional problems as a result of being in a war zone.

Typically, the ‘high intensity’ trainees treat patients for three days a week and spend the other two receiving practical training in the university setting, while their ‘low intensity’ counterparts spend four days at work and one at university.
In focus —

Jane Jackman

Jane’s background lies in journalism – she specialised in writing about the punk rock movement – a profession often associated with alcoholism. She talks about binge-drinking for many years, and inhabited a world where everyone seemed to be taking ‘speed’ or amphetamines. Gradually, she developed a taste for heroin and its substitute methadone and alcohol lost its allure.

For the past decade, Jane has been a regular client at a community drug and alcohol team (CDAT) in south London, where she picks up her prescription of methadone and diazepam.

Continuity of care is important to her. “I must have had about five keyworkers in the first five years but I’ve had the same keyworker for the last five years and I get on very well with her.”

Her life has been bleak at times – she talks about spending up to one third of her unemployment benefit on street drugs when her prescribed dose was reduced – but taking two cats off a friend’s hands a few years ago has clearly given her a boost.

“The cats are the most therapeutic thing [in my life]. I didn’t go out to find them – they came to me. Having to take responsibility for them made me stop being such a selfish person,’ she says. “Drug addicts are self-centred.”
In focus —
Robbie and Gillian Kidd

When the roads are busy, it can take up to two hours to reach south London from Robbie Kidd’s home in the outer fringes of London. But, he and his parents endured a year or so of weekly journeys across London to the Maudsley Hospital in order to get Robbie the help he needed.

— Gill, mother of Robbie aged 18

“Without the Maudsley’s help, I would still be stuck at home all day with Robbie trying to get him out of the shower”

Robbie’s early teens were blighted by an overpowering need to wash himself repeatedly before leaving home. “I was always running late and sometimes I’d miss appointments because I wasn’t ready at all,” he says.

Naturally, his schooling was disrupted by his compulsion. Now 18, he has enrolled on a two-year construction course at a local college. The thought of being outside working on muddy sites doesn’t faze him at all.

“I’m a lot better than I used to be and things are a lot more enjoyable. I’m grateful for the help. Rather than being “cured”, I feel I have kicked a habit. It’s about learning not to worry or do the rituals that I needed to do before.”

His mother Gill describes the treatment, which included medication for a period, as ‘excellent’. “At first, we couldn’t get him there in time and he used to fight me all the way in the car, but something suddenly clicked and he started improving. He’s still a bit quirky, but then I’ve got two other children and they’re quirky in other ways. The main thing is that he can now live a life as full as he wants it to be.”
For the last thirty years mental health services have been moving away from a system of care dominated by long-stay Victorian asylums focused on containment, towards one which is focused on early intervention and prevention, with the emphasis on treatment in the community.

At the same time, it is important that anyone who needs hospital care receives it – in an environment which is safe, secure and therapeutic. Major plans are underway to improve our inpatient services.

Recent developments include last year's opening of our 89-bed, £35.5m Medium Secure Unit (MSU) at Bethlem Royal Hospital, River House. In January 2009, Lambeth inpatient services previously based at St Thomas' Hospital moved to the new Lloyd Still ward at Lambeth Hospital, which involved a £4.2m conversion of office space.

A major refurbishment project has been taking place this year to enable us to improve inpatient care for people with learning disabilities. The new 13-bed Weston Unit, opens at Bethlem Royal Hospital in July 2009.

In the year ahead we are planning to relocate SLaM inpatient services currently based at the York Clinic, Guy's Hospital. One of the benefits of this plan is that we will be able to reprovide these services within an environment purpose built for mental health. It will also help to save money which is currently tied up, in part, in the operational costs of running services from an acute hospital site.

Over the course of the year, we also involved people in thinking about the future of the Maudsley Hospital site. The starting point for this was the allocation of money by the Trust Board to explore the development of a new ward block. The challenge was to think about how to use this opportunity as a way of changing the look and feel of the Maudsley. A wide range of people came along to a series of workshops and submitted their comments on-line – all of which will be used to generate ideas from architects on generating a long-term plan for the hospital.
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Looking back on her 20-year history of involvement with mental health services, Sue says her life has ‘turned around by 180 degrees’ in recent years. Following her last admission to the Ladywell Unit, she began returning to the unit in an unpaid voluntary capacity.

At first, she passed on her computing skills and now runs ‘feel good’ groups a couple of times a week. “I tidy up people’s nails, and give them – men or women – a nice manicure.”

“At the time of her last admission, Sue was virtually a prisoner in her own home. “It was my fear of being hurt. I’d had a pretty rough childhood and had decided I needed to protect myself as much as possible. I’d moved home to a new area of Lewisham and heard bad things about the area. I ended up not going anywhere – whereas now I can’t stay in.”

“Initially with support from a local voluntary group, Sue began using public transport again. Gradually, she has taken on a bigger role in the Trust. As a paid ‘link worker’, she helps to run community meetings on wards at the Ladywell Unit.

Since passing a training course in interviewing skills at the end of 2008, she has interviewed staff applying for posts in the trust. “I feel like I’m treated as an equal partner on the interview panels. Things are changing and our views count.”
It offered me safety. If I hadn’t been in that situation, I probably wouldn’t be alive”

Looking back, he feels he was probably battling the condition for many years before finally receiving a diagnosis and treatment a few years ago. Mr Lee is convinced that ‘there is no such thing as recovery’ from a mental health condition and prefers to use the words ‘continual management’ to describe what works for him.

Patrick now takes anti-depressant medication and also attends cognitive behavioural therapy sessions with a group of fellow service users at the Maudsley Hospital. He continues to receive valued support from a member of the home treatment team and sees his psychiatrist as an outpatient.

“I also teach poetry on a voluntary basis on Powell Ward at the Ladywell Unit in Lewisham. People often start to talk about their own experiences after we have read a particular piece. But some people just sit and listen.”

Even when severely depressed, Patrick found he couldn’t help noticing some of the flaws in the way the ward operated.

Though he stresses that many staff deliver excellent care and appreciates that resources can be stretched at times, he feels that communication – both between staff members and with patients – could be improved.

He’s now putting the lessons he learned from his hospital stays to good use as a member of the Service Users in Treatment and Education initiative. “Sometimes they call me in to help with inductions. Hopefully, by giving our experiences we are helping to improve the service,” he says.
In focus —
New technology to revolutionise research

A groundbreaking technological development at SLaM could help transform the speed with which research is translated into practice.

The Case Register Interactive Research (CRIS) application enables researchers to search the 118,000 entries on SLaM’s electronic patient records system at the touch of a button, and in a way that does not compromise the confidentiality of individual service users.

Up until now, only 20% of the information held on the SLaM system was available for research. Researchers had to read through each of the case notes from a patient’s electronic record to extract the information they needed. “It was very time consuming and laborious, and it meant that it could take months or years to do a small project,” says Professor Simon Lovestone, Director of our specialist National Institute for Health Research (NIHR) Biomedical Research Centre – the only one in the U.K devoted to mental health. “Now, we can search through tens of thousands of records in seconds.”

The introduction of CRIS means that anonymised, automated searches are possible on unstructured information like case notes, vastly accelerating and expanding the scope for research.

It gives researchers instant access to the vast library of electronic patient records which has been developed at SLaM over the last 10 years.

“Now, we can search through tens of thousands of records in seconds.”

— Professor Simon Lovestone
Director of our specialist National Institute for Health Research (NIHR) Biomedical Research Centre
In focus —

Tom Cromwell

“The fact that I’m now a nurse is testament to the treatment I received at the Maudsley”

— says Tom, who overcame his phobia for sickness and is now a qualified nurse.

Having just completed a three-year nursing course, he is about to take up his first staff nurse post in an accident and emergency department in a hospital in Berkshire.

What makes his career choice noteworthy is the fact that at the age of 12, Tom had a phobia for illness and, more specifically, vomiting. Referred to the Maudsley Hospital, he was diagnosed as having a mild obsessive compulsive disorder (OCD) and attended a clinic on a weekly basis for almost a year.

Tom was encouraged to confront his fears in a programme involving ‘gradual exposure’. “I used to go on to the wards at King’s College Hospital with my therapist and eat food out of airline sick bags. It might sound funny – but it worked.”

Tom, who shares a house with his girlfriend, lists playing the drums and bass guitar and chess as hobbies he enjoys when work demands allow. Looking back, he says he was discharged from the Maudsley once his ‘compulsions and obsessions’ had decreased. “But it took me a while to get used to the idea that I’m OK now.”
Matt thought that having emotional ups and downs was just part and parcel of an actor’s life. It wasn’t until he was picked up by police on the south coast – with thoughts of suicide on his mind – that he first began to accept that he needed help.

“I had had problems before but they had always been “kept in the family” and I had never been given a diagnosis.”

Thanks to concerted help from members of a community mental health team based in Streatham, Matt feels his life is back on track. He is about to start touring various centres in Lambeth and Southwark performing a one-man play. After the 90-minute performance, members of the audience are invited to air their responses to the various moral issues raised in the play.

Diagnosed with bipolar disorder and on regular medication, Matt feels the SLaM team promoted his recovery by meeting some key criteria: “They don’t patronise, they try to help but don’t claim they have the ultimate answer and they listen.” He adds: “I’ve had remarkably good help.”
In focus —

Driving quality

You might think that the business of making cars doesn’t have a lot in common with caring for people who have been admitted to mental health units. But you’d be wrong...

Nurses and other professionals working on SLaM’s 70 inpatient units are being encouraged to take a leaf out of the manual that propelled Toyota into being a phenomenally successful car company.

‘Lean thinking’ – the radical business model that helped the Japanese firm to gain pole position in the international league table of car manufacturers – is based on the belief that any business or service will only flourish if everyone in the organisation focuses on the customer and strives to be as efficient and as effective as possible.

Through the Releasing Time to Care (Productive Mental Health Ward) project, clinical staff have experienced Toyota’s model and success first hand. And it is one of a range of techniques being introduced across SLaM’s inpatient services to improve the patient experience.

This year marked the launch of the Achieving Inpatient Quality Improvement Programme (AIQUIP), which aims to create a fresh momentum for change and help staff to pool ideas and learn from each other’s successes.

“AIQUIP is an umbrella term for a number of initiatives, projects, activities and workstreams that are going on within the organisation that aim to improve our inpatient services,” says Elaine Rumble, one of SLaM’s deputy directors of nursing. “For example, a couple of wards have signed up to the Star Wards initiative, which was set up by the charity ‘Bright’. It aims to make the patient stay more productive and help people to engage in more activities.”

The accreditation process is very rigorous and takes about ten months to go through,” says Elaine. “There are nearly 300 standards that each ward has to achieve. Being accredited means the Royal College has acknowledged that the unit has high standards of patient care and is well organised. It’s great for staff to get that external validation.”

Five wards have already been accredited, four with excellence.

Another element of AIQUIP that is proving popular with ward staff is the Accreditation for Acute Inpatient Mental Health Services (AIMS), which is facilitated by the Royal College of Psychiatrists.
In focus —
SHARP scores all round

“It’s not just about fresh air and exercise,” says striker and winger Davian. “It’s about getting to know different people from different backgrounds and hearing other people’s views on life. Sometimes you have issues and it’s good to get other’s thoughts on whatever situation you’re in.”

— The 26 year old was reflecting on the bonds he has formed since joining the Social Inclusion Hope and Recovery (SHARP) football team.

The Brixton-based football team is just one initiative set up by SHARP. The team’s remit includes promoting involvement in vocational and other activities for mental health service users within Lambeth. Once engaged in the football group there is the possibility of being offered further interventions such as talking therapies, vocational guidance and healthy living advice.

“The idea was to find a place and space for the guys where they can get together and enjoy themselves doing something as beautiful as football.”

— Raul Savioz

The pride is shared by Andrew who has captained the team twice following a period when he had spent time in hospital. “It was an honour to captain the team and a real responsibility I’d never been a captain of anything before. There’s a really good team spirit, especially when we’re winning.”

—to be honest the first time I was told about the guys I had no hands on experience of working with mental health service users and I didn’t know what to expect,” says coach Steve Boakye, who works for Fulham FC’s Kickz initiative. “But everyone just wanted to play football. And I have to say, I’m really proud of the way the team is developing.”
In focus —
John Ryan

After receiving cognitive behavioural therapy and ‘talking therapies’ over several years for problems that ranged from depression to addiction, John describes himself as having been ‘in recovery’ for almost two years.

“I think the staff were absolutely excellent. They were very understanding and non-judgemental, which is especially important when you have problems of this type.”

In recent months, he completed the ‘Changing Minds’ programme which qualifies him to act as a trainer in various SLaM training events and educational programmes.

“I think people are starting to recognise that it’s not much good just treating the symptoms and are developing a more holistic approach. It’s equally important to deal with the causes, otherwise you could deal with symptoms forever.”

Getting physically fit again has been a key component in John’s road to recovery. A former keen weightlifter – the sport has taken a toll on his joints – John is now back in the gym after a long lay-off but prefers to focus on aerobic activities such as cycling.
Karen is slowly putting her life back together after a short admission at Bethlem Royal Hospital, Beckenham, and a period on a rehabilitation unit. One of the activities that provides structure in her life is a twice-weekly knitting group held in a shop in central London.

“It’s nice to be in a group of people who knit. We just talk about general stuff.”

“If you spend most of your time alone, then you need to be in a group environment sometimes”, she explains.

As a child Karen learned to knit at her mother’s side but hadn’t pursued it as a hobby for a few years – while she was busy studying for a degree on a part-time basis – until her interest was rekindled when she saw some patients knitting while in hospital.

“Knitting is a very therapeutic thing to do, and there are apparently studies that show it can be good for your mental health.”
In focus —
A hard Act to follow?

Kay Burton and her team have had a challenging and successful year getting staff across SLaM up to speed on the revised Mental Health Act (MHA), which changes a system that’s been around for 25 years. Protecting patients’ rights and ensuring the Trust keeps to the letter of the law is central to what they do every day, but the new legislation brought an unprecedented demand for training for hundreds of nurses, doctors and other health professionals.

A programme to train doctors in the new roles of Approved Clinician was one of the biggest challenges. Bob Lepper the MHA Advisor/Policy Lead and Dr Frank Holloway, Clinical Director for Croydon, worked together closely to deliver the programme.

As part of the preparation for the changes, Kay helped to organise an event to give black and minority ethnic groups and service users and carers a chance to hear how reforms would affect them.

“Sometimes a query is more complicated and we have to dig around into other pieces of legislation – such as the Children Act, Human Rights Act or the Mental Capacity Act – before giving advice. The Trust also uses external mental health lawyers to give additional guidance.”

Though they are not required to have formal legal qualifications, Kay and the team have acquired a great deal of knowledge and can respond to many queries themselves.

Their predecessors wrote the original book on the Act – The Maze. This was one of the most popular guides to the Mental Health Act, running to several editions. Bob Lepper has been putting the final touches to the new Maze guide, which aims to carry on that tradition, updated with the new legislation.

Kay has been impressed by the huge team effort that ushered in the reforms with no major hiccups. “Staff showed great willingness to learn and the uptake on training was excellent. I’d like to thank everybody at SLaM for their cooperation.”

“Mental health law is quite complex and we provide advice to all staff.”

While dealing with all the training and managing change, the crucial task of providing detailed advice on complying with legislation has continued.

“Mental health law is quite complex and we provide advice to all staff. Our five Mental Health Act offices, spread across the Trust, are the first port of call for anyone with a routine query,” says Kay.
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In focus —

Hitting the right note

A new initiative is helping service users in Lewisham take their first steps into the music industry. The ‘Bouncing Trax’ project is proving to be a big hit with younger people with mental health problems, many of whom were previously reluctant to engage with services.

Students learn how to compose and produce musical tracks using the latest technology, while those with a particular talent for singing or rapping finally have an outlet. Everyone who completes the eight-week programme walks away with a certificate and a CD that captures his or her work for posterity. A photograph of the client printed on the CD’s cover and the disc itself, provides the finishing touch.

Run by the Community Opportunities Service (COS), the project shows just how far things have come in recent years since traditional ‘day care’ provision was overhauled. Promoting social inclusion and forging links in the local community is now the name of the game, rather than expecting people to attend a dedicated day centre offering a narrow range of activities.

Team leader Polly Moy’s friendship with music producer Uschi Classen proved to be the catalyst that triggered the project’s creation. “Uschi is a professional who has released her own album and worked alongside performers such as Kylie Minogue,” Polly explains. “But she also has a very good understanding of mental health issues and I thought she would have a lot to offer our clients.”

By the start of 2008, an initial group of ten clients, all of whom were referred by early intervention or forensic services, were learning how to program and write their own music using computers and keyboards. All of the five students who completed the course went on to enrol on further music or design courses.

Two music engineers, Louis Barnes-Warrell and Ahmad Dayes, from the Deptford-based Midi Music Company, where the sessions took place, are part of the Bouncing Trax team who provide technical support, training and encouragement. The company, which has charity status, was set up in 1995 with a remit to inspire local children and young people to further their education or enter the creative and music industries.

“The course is designed to target those who usually don’t engage with the standard mental health services provided. Some students have been very unwell. They might hear voices or have quite severe delusions. But we have been astonished at their ability to focus for a solid three hours at a stretch and learn a whole computer program,” says Polly. “The creative ability of these students has impressed us all. It’s quite magical what the course has done for people’s self esteem.”

After a bid to buy five sets of portable recording units received the green light, Polly and colleagues are keen to introduce the equipment to inpatient groups at the Ladywell Unit. “This is all part of the drive to improve people’s therapeutic experiences as inpatients and move them towards recovery. One idea is to run three or four week courses on the unit and start to link people into the Bouncing Trax programme when they leave the ward.”
The Board of Directors:

— is collectively responsible for the exercise of the powers and the performance of the Trust
— provides active leadership of the Trust within a framework of prudent and effective controls which enables risk to be assessed and managed
— is responsible for ensuring compliance by the Trust with its terms of authorisation, its constitution, mandatory guidance issued by Monitor, relevant statutory requirements and contractual obligations
— sets the Trust’s strategic aims, taking into consideration the views of the Members’ Council, ensuring that the necessary financial and human resources are in place for the Trust to meet its objectives and review management performance
— is responsible for ensuring the quality and safety of healthcare services, education, training and research delivered by the Trust and applying the principles and standards of clinical governance set out by the Department of Health, the Care Quality Commission, and other relevant NHS bodies
— is responsible for ensuring that the Trust exercises its functions effectively, efficiently and economically
— sets the Trust’s values and standards of conduct and ensures that its obligations to its members, patients and other stakeholders are understood and met.

As a unitary board, all Directors, Executive and Non Executive have joint responsibility for every decision of the Board of Directors and share the same liability. This does not impact upon the particular responsibilities of the Chief Executive as the accounting officer.

Non Executive Directors are responsible for determining appropriate levels of remuneration of Executive Directors and have a prime role in appointing – and where necessary removing – Executive Directors, and in succession planning.

The Board of Directors meets in public throughout the year, with private sessions where required. There is also a regular programme of seminars.
The Board of Directors reviewed its committee structure in July 2008. The main change was the approval of revised terms of reference and membership of the renamed Patient Safety and Service Improvement Committee.

Sub Committees

Area

Assurance / Scrutiny
  — Audit
  — Patient safety and service improvement
  — Serious untoward incidents
  — Complaints monitoring
  — Activity and finance
  — Remuneration

Strategy / Planning
  — Estates strategy
  — Information services strategy
  — Workforce development
  — Research and development
Audit Committee
The Audit Committee’s key objectives are to monitor, review, and report to the Board of Directors on whether the Trust’s processes in the following areas are efficient and effective: internal control and risk management; internal audit; external audit and financial reporting.

Remuneration Committee
The role of the Remuneration Committee is to advise and assist the Board of Directors on: meeting its responsibilities to ensure appropriate remuneration and terms of service for the Chief Executive and other Executive Directors; all aspects of the remuneration and terms of service of senior managers in the Trust.

Individual objectives are agreed with the Chief Executive for each of the Executive Directors. Annual cost of living awards and increments are subject to achieving objectives. Executive Directors are employed on permanent contracts with six month notice periods. Any redundancy payments [should this situation arise] would be made in line with current NHS policy.

Charitable funds
The Trust is the corporate Trustee for the South London and Maudsley charitable funds and has recently reviewed the governance arrangements for planning the future strategy for the use of these funds and for the processing of grant applications.

Trust Executive
The Trust Executive reports to the Trust Board. It exists to promote the effective functioning of the Executive management team, to ensure that clinical advice is properly presented and considered by the Executive management team, to make decisions on the allocation of resources within the Scheme of Delegation and to ensure that the Executive management team has an effective understanding of the operational functioning of the Trust.

The Trust Executive transacts its business through four types of meeting: Strategy; Governance; Formal and Service Quality. Key issues arising from the meetings of the Trust Executive are reported to the Trust Board via the Chief Executive’s report which is a standing agenda item. This report also includes a report from the monthly Chief Executive’s performance management review meetings with the Trust’s directorates which is referred to in the Statement of Internal Control, as well as updates on issues relating to the wider health service in London and key items raised in the NHS Chief Executive’s weekly bulletin. An additional section on service quality was introduced in 2008.

Scheme of Delegation
The Trust operates a Scheme of Delegation which provides examples of how powers may be reserved to the Board, generally for matters for which it is held legally accountable or through its terms of authorisation, whilst at the same time delegating to the appropriate level the detailed application of Trust policies and procedures. That said, the Board remains accountable for all of its
functions – including those delegated to the Chair, individual directors or officers – and therefore expects to receive information about the exercise of delegated functions to enable it to maintain a monitoring role.

Working with the Members’ Council
The Trust has a membership base of over 7,500 who have elected an active Members’ Council. The Chair has actively encouraged input from the Members’ Council in the work of the Trust. Two joint seminars have been held between the Members’ Council and Board of Directors to consider their respective roles and responsibilities. A work programme has been developed which is monitored at the quarterly meetings of the Members’ Council. A group has been established to plan agendas for meetings of the Members’ Council. The Chair welcomes and encourages open access to individuals on the Members’ Council.

How the Board operates
The system established for the appraisal of performance has been monitored by the Nominations Committee for Non Executive Directors and the Remuneration Committee for Executive Directors. The Trust integrates governance principles and procedures within its operations and management arrangements.

The Board of Directors has reviewed the Trust’s compliance with the NHS Foundation Trust Code of Governance, and considers that the Trust has complied in all material respects.

The one exception is that the Trust has decided not to appoint a Senior Independent Director as we have robust and thorough scrutiny processes in place. This involves objective, independent and thorough appraisal of the performance of the Chair through the use of an external consultant; structured feedback from a range of external and internal stakeholders; the opportunity for direct contact between the Members’ Council and all Board Directors, including attendance by Non Executive Directors at Members’ Council meetings which help to integrate the Trust’s governance arrangements.

The Board of Directors has continued to assess the independence of its Non Executive Directors further to the requirements of the Code of Governance, and considers that each Non Executive Director is independent in character and judgement. That assessment took account of the fact that:

— Robert Coomber was formerly, and prior to his appointment to SLaM, the Chief Executive of the London Borough of Southwark – a local authority which has a business relationship with the Trust
— Professor Eric Taylor is an appointed representative of the Trust’s University Medical School – King’s College London.

These relationships are declared where relevant at each meeting of the Board of Directors. The Board of Directors considers that the materiality and circumstances relating to these relationships are such that they do not affect, nor could appear to affect, the independence of the directors concerned.

The Board of Directors has an appropriate balance of skills and experience between the Executive Director posts (five) and Non Executive Director posts (eight including the Chair). There are plans to recruit to the Non Executive vacancy in 2009/10. Individual evaluation of directors’ performance is carried out by the Chair (for Non Executive Directors and the Chief Executive) and by the Chief Executive (for Executive Directors). The Nominations Committee receives reports on behalf of the Members’ Council on the process and outcome of appraisal for the Chair and Non Executive Directors. The Remuneration Committee receives a report from the Chief Executive on the performance of all Executive Directors and the Chair reports to the Remuneration Committee on the performance of the Chief Executive.

Principal risks
The principal risks facing the Trust, and how they are managed, are set out in our Assurance Framework. The Framework covers financial and governance issues which are monitored by the Audit Committee and clinical service issues which are monitored by the Patient Safety and Service Improvement Committee.
King's Health Partners Academic Health Sciences Centre (AHSC)

King's Health Partners is a formal, strategic alliance involving SLaM, King’s College London and Guy’s and St Thomas’ and King’s College Hospital NHS Foundation Trusts.

Comprising one of the world’s leading research-led universities and three of London’s most successful NHS Foundation Trusts, we believe King’s Health Partners is in a unique position to deliver groundbreaking advances in physical and mental health care. Our patient population is one of the most economically and ethnically diverse in the world, which means that our work will have global relevance and application. As an AHSC, we will create a stronger and more formal collaboration in basic and translational research, and health and knowledge investment. By integrating our clinical strategies we will focus on patient need in a way that moves beyond historical divisions and traditional institution.

King’s Health Partners 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 governance arrangements for King’s Health Partners are as follows:

**Partnership Board**
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. 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 plan is to recruit an independent Chair of the Partnership Board in the next year.

**Executive**
A transitional Executive was established within the last year to shape the development of King’s Health Partners and steer a course through the AHSC accreditation process (which involved scrutiny of our application by international expert panel appointed by the Department of Health).

A permanent Executive Director has been appointed whose responsibilities include chairing the Executive. The Executive will also be responsible for the development, co-ordination and performance of Clinical Academic...
Groups (CAGs), which will progressively be brought within the formal governance framework through an internal approval process that will ensure they are fit for purpose. This process, which will be managed by the Executive on behalf of the Partnership Board, will require each CAG to demonstrate that it has strong leadership, a coherent strategy and a credible business plan to deliver that strategy.

**Partnership Agreement**
In the coming year we will develop a Partnership Agreement. The Agreement will set out the retention of ultimate powers and accountability by each of the individual partners, the authority delegated by them to the Partnership Board, the tasks expected of the Executive, and the roles of Clinical Academic Groups (new structures which will bring together clinical services and academic activities within a series of single managerial units).

**Environmental matters**
The Trust's environment / carbon management group is responsible for:

- procurement policies that strengthen communities, improve health and sustain the environment
- building skills and providing routes into employment for disadvantaged and hard-to-employ groups
- sustainable management of waste, resources and energy
- improved access to facilities
- design, construction and refurbishment of buildings to promote social, economic and environmental sustainability.

**Contractual arrangements**
We have one of the most extensive contract portfolios in the NHS involving relationships with most Primary Care Trusts (PCTs) in the country.

We receive approximately £270m clinical income per year, 80% of which comes from contracts with four PCTs: Croydon, Lambeth, Lewisham and Southwark. We have a close working relationship with the local authorities within each of these Boroughs.

We also receive income from other London PCTs for tertiary work and from PCTs across the country who refer to our national specialist services.

We also act as a “sub-contractor” for local commissioners on complex and forensic care, and have service and financial relationships with the other NHS Trusts within the local health economy. In total the sub-contracted expenditure on clinical care from the Trust with other providers is over £30m per year. We also receive funding for education and training through contracts with NHS London.

**Exposure to price, credit, liquidity and cash flow risk**

--- **Liquidity**
Our net operating costs are incurred under contracts with Primary Care Trusts (PCTs) and other public sector bodies, which are financed from resources voted annually by Parliament. We finance our capital expenditure from funds internally generated, but have the ability to borrow against the Prudential Borrowing Limit. At the year-end the Trust had £52m cash and a £15m working capital facility in place. The Trust is not, therefore, exposed to significant liquidity risks.

--- **Credit**
The majority of our income comes from contracts with other public sector bodies, and we therefore have low exposure to credit risk.

--- **Price**
The majority of our income is covered by contracts signed with PCTs at the start of the financial year and paid over 12 months in equal installments. The contracts with PCTs are adjusted in line with a nationally agreed generic inflation factor that covers pay and non pay inflation and other specific national cost pressures such as new drugs.

**Research and Development (R&D)**
Our research partner the Institute of Psychiatry (IoP), King’s College London held research grants to a total value of £97m at 31 March 2009. The Institute’s research quality, much of which is
undertaken in partnership with SLaM, was rated strongly in the Research Assessment Exercise 2008 – 95% was classified as “internationally regarded, internationally excellent or world-leading”. The Institute now accounts for 32 out of the 101 ‘world leading’ research activity units in psychiatry, clinical psychology and neuroscience in the U.K. Examples of how our research is being used are highlighted elsewhere within this annual report.

Equality of opportunity
Our Disability Equality Scheme describes how we aim to promote equality of opportunity, eliminate discrimination and harassment and remove the barriers faced by staff and service users with a disability.

As a member of the Mindful Employer initiative (www.mindfulemployer.net) we are committed to the recruitment and retention of people experiencing mental ill health and in increasing awareness of mental health in the workplace.

As an organisation which uses the Disability Symbol we have agreed with Jobcentre Plus that we will take action on these following five commitments:

— to interview all disabled applicants who meet the minimum criteria for a job vacancy and consider them on their abilities
— to ensure there is a mechanism in place to discuss, at any time, but at least once a year, with disabled employees what can be done to make sure they can develop and use their abilities
— to make every effort when employees become disabled to make sure they stay in employment
— to take action to ensure that all employees develop the appropriate level of disability awareness needed to make these commitments work
— each year to review the five commitments and what has been achieved, plan ways to improve on them and let employees and Jobcentre Plus know about progress and future plans.

We are one of 20 NHS trusts named as NHS Employers Equality and Diversity Partners, after demonstrating a real commitment to embedding equality and diversity within the Trust.

The 20 NHS trusts were awarded Partner status following an assessment which looked at areas such as board level commitment to equality and diversity, compliance with current legislation and evidence of good practice. NHS Employers will be working with us over the next twelve months to promote and develop the equality and diversity agenda, and share leading good practice with other trusts.

Going concern
After making enquiries, the directors have a reasonable expectation that South London and Maudsley NHS Foundation Trust has adequate resources to continue in operational existence for the foreseeable future. For this reason,
they continue to adopt the going concern basis in preparing the account.

Complaints
There were two requests for Independent Review by the Healthcare Commission, where the original complaint was made during the same period. This accounts for 0.5% of the number of complaints received at the first stage going to the second stage of the Complaints procedure. In both cases the Healthcare Commission referred the complaint back for further resolution.

This we carried out a survey of complainants asking them how they felt we managed their complaint. Over 80% of complainants who returned their questionnaire felt the Trust had taken their concerns seriously and over all were satisfied in how their complaint was managed. The vast majority of complainants felt they were not discriminated against as a result of raising their complaint, which will is positive in encouraging more service user feedback and accessibility to the complaints procedure.

In the year ahead we will be implementing the new NHS Complaints procedure in line with new statutory regulations. The new procedure is less process driven. It is hoped this new approach to complaints management will further improve the service user experience.

Involving and communicating with staff
Our quarterly Joint Staff Committee provides an opportunity to formally consult and negotiate with staff side representatives on issues affecting staff (the minutes of these meetings are published on our intranet). We also work in partnership with staff side colleagues on many different issues throughout the year, and hold consultation meetings with individual staff groups in relation to service changes.

We hold a range of events to involve staff in the work of the Trust. These include our annual Trust conference, quarterly senior leadership group meetings and an annual clinical team leaders event.

We were among the highest performing 20% of mental health and learning disability NHS Trusts in the country in 7 out of the 36 areas covered in the Healthcare Commission’s 2008 national staff survey. SLaM scored above the national average in nearly half of all the areas covered. Staff said they would recommend the Trust to others as a place to work, are able to contribute towards improvements at work, and receive access to training, learning and development opportunities to help them perform their jobs better.

77% of respondents in the staff survey (292 people) said that the Trust’s in-house newsletter ‘SLaM News’ is a useful way of finding out about what’s happening at the Trust, 76% said the same about the weekly e-bulletin sent to all staff and 76% said the same about the Trust intranet.

The papers for the monthly public meetings of the Board of Directors are published on the Trust website and intranet (including finance reports).
Management commentary —
Operating and finance review

Financial position
This year we reported a net deficit of £6.7m. This was £6.8m below the plan agreed by the Board at the start of the year although our operating surplus of £18.4m remained on plan. The net deficit was caused following the revaluation of our estate and subsequent impairment of some fixed assets. There was no cash loss as a result of these impairments and cash reserves at year end were maintained at £52m, providing both the headroom to manage unexpected events and a source of funds to invest in new capital developments. Details on our financial performance are shown below:

This performance is set against a backdrop of the issues set out on the right page.

- Internal investment of £7.3m using non recurring funding and an in year generated surplus. Significant investment was made in:
  - the development of Information and Communications Technology (ICT) infrastructure, including our patient information system (EPIS), electronic prescribing and security/storage of data — estates and facilities, including compliance work, energy initiatives, new signs and refurbishment of Trust facilities
  - clinical directorates to accelerate service quality and improvement, improve cleanliness and improve monitoring of the patient experience.

- A revaluation of our estate, resulting in a net decrease of £40m of which £9.2m of impairments which were taken to the Income and Expenditure (I&E) account.

- A reduction in Research and Development (R&D) income of £8m following a decrease in transitional support provided by the Department of Health

- Interest received of £2.1m despite a significant reduction in interest rates in the second half of the year

- A wide ranging programme of cost improvements required to meet Government efficiency targets, cost pressures and re-investment into more efficient service delivery and other improvements.

The Trust is assigned an annual financial risk rating by Monitor (the independent regulator of Foundation Trusts) based upon four criteria: achievement of Annual Plan; underlying performance; financial efficiency; and liquidity. We achieved a rating of 4 (out of 5) in 2008/9 which indicates no regulatory concerns.

<table>
<thead>
<tr>
<th>Income and expenditure position</th>
<th>£000s</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total Income</td>
<td>354,606</td>
</tr>
<tr>
<td>Expenses</td>
<td>(336,201)</td>
</tr>
<tr>
<td>Operating surplus</td>
<td>18,405</td>
</tr>
<tr>
<td>Profit on disposal</td>
<td>130</td>
</tr>
<tr>
<td>Depreciation</td>
<td>(7,910)</td>
</tr>
<tr>
<td>Interest etc</td>
<td>1,948</td>
</tr>
<tr>
<td>Dividends to Govnt</td>
<td>(10,044)</td>
</tr>
<tr>
<td>Impairment of assets</td>
<td>(9,198)</td>
</tr>
<tr>
<td>Net deficit</td>
<td>(6,669)</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Cash position</th>
<th>£000s</th>
</tr>
</thead>
<tbody>
<tr>
<td>Opening cash balance</td>
<td>52,873</td>
</tr>
<tr>
<td>Add – operating surplus</td>
<td>18,405</td>
</tr>
<tr>
<td>Add – changes in working capital</td>
<td>4,537</td>
</tr>
<tr>
<td>Less – financing and dividend</td>
<td>(7,976)</td>
</tr>
<tr>
<td>Less – net capital expenditure</td>
<td>(14,882)</td>
</tr>
<tr>
<td>Less – non cash I&amp;E items</td>
<td>(887)</td>
</tr>
<tr>
<td>Closing cash balance</td>
<td>52,070</td>
</tr>
</tbody>
</table>
Past trends in income, retained surplus and assets employed

The charts below show the trends in turnover, retained surplus and assets employed over a six year period from 2003/04 to 2008/09.

Turnover has risen by 39% in the past five years and by 5.2% in 2008/09. The majority of income (81%) is received from NHS Primary Care Trusts.

Prior to Foundation Trust status in November 2006, the target for NHS Trusts was to break even. In our first 17 months as a Foundation Trust, we generated a retained surplus of £6.9m. In 2008/09 we recorded a net deficit of £6.7m following £9.2m of fixed asset impairments.
Management commentary –
Operating and finance review

The net assets of the Trust decreased by 13.1% in 2008/09. Asset values decreased due to a revaluation of the estate following the recent fall in land/building values and the impairment of various building works undertaken during the year.

Future performance
We face a number of key challenges in the years ahead, including:

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The impact of the downturn in the economy is likely to be felt across all publicly funded services over the next few years. This will mean the efficiency target for the NHS will go up in future. In 2010/11 it is planned to rise to 3.5%. From 2011/12, a new public spending settlement for the NHS has yet to be agreed, but the pressure to develop and maintain services within limited funds is expected to continue for the foreseeable future.

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Following the recent changes made to R&D funding streams, the Department of Health is also set to change and update three other national funding levies – Service Increment for Training (SIFT), Medical and Dental Education Levy (MADEL) and Non Medical Education and Training (NMET) – that provide us with over £13m of education and training funds. It is expected that shadow prices will operate in 2009/10 prior to a new funding formulae being implemented in 2010/11 (under transitional arrangements). As with R&D, any changes made to funding streams at a national level, could carry income risks. These risks will be determined in 2009/10 prior to the implementation of new funding mechanism(s) in 2010/11.

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Work continues on developing currencies for use in the commissioning of mental health services for adults.
of working age and older people. The ultimate goal is the creation of a national tariff for these currencies. Following the consultation Options for the Future of Payment by Results (PbR) 2008/09 to 2010/11, which highlighted mental health as a priority area for PbR development, the Care Pathways and Package Project approach of grouping service users into categories based on need has been accepted as the model that will be pursued nationally. It is intended that a currency for mental health activity will be available for use nationally in 2010/11. This should ultimately lead to activity based contracts, using either a national or locally derived set of tariffs to determine future payments to the Trust.

— We will need to take account of national changes to the way we report our finances. The move to International Financial Reporting Standards (IFRS) will have an impact on capital expenditure, particularly in relation to how we account for the refurbishment of property. Any corresponding impact on revenue will need to be taken account of when setting our capital programme.

Name of Trust’s auditor: Audit Commission

Cost allocation requirements
We have complied with cost allocation and charging requirements set out in HM Treasury and office of public sector information guidance.

Accounts
Accounting policies for pensions and other retirement benefits are set out in note one to the full accounts and details of senior employees’ remuneration can be found later on within this report.

The accounts have been prepared under a direction issued by Monitor.
Quality report —

The Health Bill 2009 requires all NHS organisations to publish an annual account of quality.

This will be a statutory requirement from April 2010. This year, NHS Foundation Trusts are required to report on quality for 2008/2009 and to publish information on quality within the annual report.

The quality account aims to:

— make the Trust more transparent and accountable for its performance
— engage both stakeholders and staff in the quality agenda
— make progress to demonstrate real improvements in service quality.

This first report signals the beginning of a process which will build for the future, develop reliable measures of service quality and will enable us to further develop relationships of integrity with our service users, commissioners and partner agencies.

There are three broad areas of quality as outlined by Darzi in High Quality Care for All, DH 2008; patient safety, patient experience and clinical outcomes.

The Board of Directors is committed to:

— improving service user and carer experience and satisfaction
— improving clinical outcomes and quality of life for people who use our services
— reducing the number of avoidable adverse incidents and preventable deaths.

The Board of Directors will ensure that the quality account becomes a real driver for service improvement in these three areas, and that the Trust builds capability and expertise in managing quality consistently. With our Academic Health Science Centre partners we aim to provide services which stand up to comparison with the best in the world. In doing so, we will support innovation and reward excellence.

In order for the quality account to evolve, we will need to engage with stakeholders. In particular, we will need to ensure that our priorities align with those of service users and commissioners.

Stuart Bell
Chief Executive
Achievements and initiatives in 2008/09

Compliance with Standards for Better Health – Core standards In April 2009 the Board of Directors returned a declaration of full compliance across all of the Care Quality Commission’s (CQC) core standards for 2008/2009. This included full compliance with the Hygiene Code of Practice. The overall health check ratings for 2008/2009 will be published by the CQC later in the year. Previous year’s performance was as follows:

<table>
<thead>
<tr>
<th>Quality of services</th>
<th>2007/08</th>
<th>2006/07</th>
<th>2005/06</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>🟢🟢🟢</td>
<td>🟢🟢🟢</td>
<td>🟢🟢🟢</td>
</tr>
<tr>
<td>Use of resources</td>
<td>🟢🟢🟢</td>
<td>🟢🟢🟢</td>
<td>🟢🟢🟢</td>
</tr>
<tr>
<td></td>
<td>Excellent</td>
<td>Good</td>
<td>Good</td>
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<tr>
<td></td>
<td>🟢🟢🟢</td>
<td>🟢🟢🟢</td>
<td>🟢🟢🟢</td>
</tr>
<tr>
<td></td>
<td>Excellent</td>
<td>Excellent</td>
<td>Fair</td>
</tr>
</tbody>
</table>

Overall performance

The overall performance rating is made up of two parts: ‘use of resources’, which looks at how effectively a trust manages its financial resources; and ‘quality of services’, which is an aggregated score of performance against national standards and targets. The below tables summarise the three years of the annual health check.

Components of quality of services

<table>
<thead>
<tr>
<th>Core Standards</th>
<th>2007/08</th>
<th>2006/07</th>
<th>2005/06</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>🟢🟢🟢</td>
<td>🟢🟢🟢</td>
<td>🟢🟢🟢</td>
</tr>
<tr>
<td>Existing national targets</td>
<td>🟢🟢🟢</td>
<td>🟢🟢🟢</td>
<td>🟢🟢🟢</td>
</tr>
<tr>
<td></td>
<td>Fully met</td>
<td>Almost met</td>
<td>Fully met</td>
</tr>
</tbody>
</table>

New national targets

<table>
<thead>
<tr>
<th>New national targets</th>
<th>2007/08</th>
<th>2006/07</th>
<th>2005/06</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>🟢🟢🟢</td>
<td>🟢🟢🟢</td>
<td>🟢🟢🟢</td>
</tr>
<tr>
<td></td>
<td>Excellent</td>
<td>Excellent</td>
<td>Excellent</td>
</tr>
</tbody>
</table>
Quality report —

Compliance with new national targets performance by indicator

New national targets assessment looks at targets outlined in National Standards, Local Action: Health and Social Care Standards and Planning Framework 2005/06 – 2007/08. In the 2007/2008 annual health check a total of 59 indicators were used to measure performance against the new national targets. Some new national targets are measured by one indicator with others being measured by up to four indicators. Indicator level performance for SLaM is detailed. Performance for 2008/2009 will be published later in the year.

<table>
<thead>
<tr>
<th>Indicators</th>
<th>2007/08</th>
<th>2006/07</th>
<th>2005/06</th>
</tr>
</thead>
<tbody>
<tr>
<td>Experience of patients</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Support in the community</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Drug misusers sustained in treatment</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Infection control</td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>Data quality on ethnic group</td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>Audit of suicide prevention</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Community mental health learn integrated working</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Compliance with guidelines concerning obesity</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Compliance with guidelines concerning schizophrenia</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Note:
Data from the last three years has been presented in the table above. However, annual amendments to indicator constructions and scoring thresholds have sometimes taken place.
NHS Litigation Authority [NHSLA] Risk Management Standards

In December 2008 we were assessed against the NHS Litigation Authority (NHSLA) Risk Management Standards at level 2 (there are 3 levels). We achieved a score of 100%. This means that, following a process of external scrutiny, we demonstrated successful implementation of policies across 50 standards in the areas of governance, competent and capable workforce, safe environment, clinical care, and learning from experience.

The Healthcare Commission and National Treatment Agency review of substances misuse services

In January 2009 we received the results of the 2007/2008 joint review held by the two regulators for substance misuse – the Healthcare Commission (now the Care Quality Commission) and the National Treatment Agency (NTA). This examined diversity in community services provision and inpatient services. Our local partnership substance misuse services in Bexley and Greenwich both received a rating of “excellent”. Two of our inpatient services – Wickham Park House at the Bethlem Royal Hospital and the Acute Assessment Unit at the Maudsley Hospital – received a rating of “excellent”. Trust staff are now assisting the National Treatment Agency in developing improvement guidance for inpatient substance misuse services.

The Healthcare Commission’s review of hospital services for people with acute mental health problems

This 2008 National review of community mental health services was a follow-up to a previous review in 2005/2006. The main areas of concerns from services users were involvement in the development of their care plans, and receiving help in finding work. Improvements included the number of services users being offered cognitive behavioural therapy and those having their physical health reviewed annually. The full Healthcare Commission report on this follow-up review can be found at: http://2008ratings.cqc.org.uk/_db/_documents/CMH_RV5.pdf

Safeguarding the rights of patients detained under the Mental Health Act

The Mental Health Act Commission (now part of the Care Quality Commission) regularly visits all services which detain people under the Mental Health Act 1983. This year it made nine recommendations to the Trust in its annual report:

— improving audits and clinical governance procedures for detained patients
— conducting a programme of Section 58 consent to treatment audits
— consideration of informal patients, locked wards and unlawful deprivation of liberty
— development of menus that combine patient satisfaction with healthy eating
— increasing visiting space whilst maintaining the necessary security at River House
— ensuring access to an Independent Advocacy Services
— resolving outstanding problems with catering
— programme of ligature point hazards audits should take place
— arrangements should be made for ensuring that patients are kept informed of their status and rights when forms are not available – Section 132.

How the 69 mental health Trusts performed in this review.

<table>
<thead>
<tr>
<th>% of Trusts</th>
<th>Rating</th>
</tr>
</thead>
<tbody>
<tr>
<td>10.4%</td>
<td>Excellent</td>
</tr>
<tr>
<td>29.9%</td>
<td>Good</td>
</tr>
<tr>
<td>43.3%</td>
<td>Fair</td>
</tr>
<tr>
<td>16.4%</td>
<td>Weak</td>
</tr>
</tbody>
</table>
These issues will continue to be monitored closely by the Trust’s Mental Health Act Committee.

In a presentation to the Board of Directors in March 2009, the Mental Health Act Commissioner for SLaM praised the quality of leadership and administration within the Trust relating to the Mental Health Act, and its commitment to ensuring that detained patients’ rights were properly respected.

**Service user experience – asking service users what they think of our services**

This year, the fifth national survey of community mental health services was co-ordinated by the Healthcare Commission. The national mental health survey involved 68 NHS trusts in England, including combined mental health and social care trusts and primary care trusts. Responses were received from more than 14,000 people of working age who used services, a response rate of 35%. People were eligible for the survey if they were aged 16 or over, and if they were either on the standard or enhanced Care Programme Approach (CPA), but were not current inpatients. The response rate for SLaM was slightly lower at 28%. We value the feedback that people give us and we have launched a campaign to encourage more people to take part in the next survey. As part of this campaign we have made a commitment to plant a tree for every completed survey we receive.

Of the people who took part in the latest survey:

— 70% rated the service they received from SLaM as ‘good’, ‘very good’ or ‘excellent’
— 17% rated it as ‘fair’
— 8% poor and 5% very poor.

One of the themes of the patient survey feedback relates to information. For example, only 34% of people said they had the number of someone from their local NHS mental health service that they could phone out of office hours. Action that we have taken to improve the information we provide to people who use our services includes:

— the development of a patient information webpage. This will give staff access to a range of material which can be printed from the desktop and given to service users. These pages will be replicated on the Trust internet site in 2009/2010
— the production of a newsletter which we sent to 20,000 people who have used our services. This includes information about how to get help in a crisis, as well as general health advice on issues such as eating well. The newsletter is also available on the new section for patients we have introduced on our website [www.slam.nhs.uk/patients](http://www.slam.nhs.uk/patients)
— the introduction of an intranet-based Patient Information Printing System (PIPS) which is designed to improve the quality and consistency of leaflets we produce about our
services and treatments. 12,000 leaflets have already been printed — the installation of new signs and creation new maps at the Bethlem, Lambeth and Maudsley Hospitals — developed using colour ‘zoning’ to make it easier for people find the way around our main hospital sites.

The national patient survey involves a relatively small, random sample of the people who use our services, which means that the most people who receive care and treatment from SLaM aren’t eligible to take part. This is why we have introduced a number of other mechanisms by which we encourage people to tell us what they think about the care and treatment we provide, involving:

— development our own survey questionnaire which was sent to a much larger sample of 10,000 people who use our services. This enables us to obtain much more detailed feedback about individual clinical teams
— launch of about 50 hand-held electronic ‘your feedback’ devices to collect feedback directly from people who are currently using our services. Each device has a number of basic questions which were developed in consultation with service users and clinical staff. The service user is given the device and can then punch in his or her answers directly. For someone receiving care within one of our inpatient services, this might involve being asked to rate the quality of the food
— introduction of a detailed feedback form on the new section for patients on our website.

It is also important for us to listen to the voice of carers. In the last year we have begun work on developing our family and carer strategy. We have invited people to tell us about their experiences, and about the kind of things they would like to see in our strategy, both via our website and a ‘listening day’.

Psychology satisfaction survey
In a two week period in November 2008, a brief satisfaction with psychology services questionnaire (21 questions) was given to every service user (across all directorates) seeing a SLaM Psychologist, or Psychological Therapist working under the management of a Psychologist. 1173 questionnaires were given to service users, 340 (29%) of which were returned. The results of this satisfaction survey are very encouraging and complement the positive results seen in the routine CORE-OM analysis in SLaM psychological therapies. The results suggest that on average, service users receiving psychological therapy from SLaM outcomes and are very satisfied with the service that they receive. Specifically:

— 90% described there levels of satisfaction with the service they received as ‘good’, ‘very good’ or ‘excellent’
— 96% said they found therapy helpful
— 94% said they had enough say in their care
— 100% said they had been listened to carefully
— 99.7% said they were treated with dignity and respect.

Quality initiatives
In the course of the last year we have launched our Achieving Inpatient Quality Improvement Programme (AIQuIP). This includes the following elements:

— Accreditation for Acute Inpatient Mental Health Services (AIMS)

AIMS is an initiative from the Royal College of Psychiatrists who, along with many different professional groups and services users, devised the standards to achieve accreditation. These cover five areas: environment; safety; timely admission and discharge; therapeutic interventions; health and safety. Service users are involved in the assessment process. Five wards in SLaM are now accredited, four of which were accredited as ‘excellent’. The programme aims to ensure that all acute and older adult wards are accredited by December 2009.

— Releasing time to care – productive wards

This initiative aims to empower staff to drive quality improvements by improving the efficiency of ward systems and processes so that staff can spend more time with services users. Areas covered include safety and reliability of care, carer satisfaction and staff wellbeing. So far there are
Quality report —

six showcase wards across SLaM, John Dickson, AL2, Behavioural Disorders Unit, Chaffinch, Westways, Hopton Road. Seven other wards have embarked on the programme in April 2009.

Quality Networks in Child and Adolescent Mental Health services (QNIC), is a quality assurance system for CAMHS inpatient services. The system is one of self assessment with external peer review across a range of standards. CAMHS units assessed last year were; the Bill Yule Unit, Snowsfield Unit, Acorn Lodge, and the Bethlem Adolescent Unit.

The Trust is a member of the Electroconvulsive Therapy Accreditation Service (ECTAS). The purpose of ECTAS is to assure and improve the quality of the administration of ECT. ECTAS has the support of the Royal College of Nursing and the Royal College of Anaesthetists. The Trust was again awarded a rating of excellence by external assessors at its last assessment.

Clinical audit

Our Clinical Audit Program in 2008/09 was divided into three priorities:

— Patient safety: This is a program of audit and re-audit of NHSLA clinical policies in preparation for NHSLA level 2 assessment. A suicide audit is also included as part of monitoring NSF standard 7 and the National Confidential Inquiry recommendations

— Clinical effectiveness: This included a series of audits of NICE guidance, priorities drawn from NHSLA list of key guidelines, recently published guidance and older guidance that has not yet been subject to Trust wide monitoring/audit

— Patient focus: Audit topics included patient rights (e.g. Section.58, MCA) and carers rights (right to carers assessment) and new CPA policy implementation.

Nursing practice assurance assessments

This year, all community and inpatient teams received the annual nursing practice assurance assessment. Assessments are conducted by a team of senior nurses who assess practice across a wide range of indicators, including safety and security; professional standards; policy implementation, record keeping and medication management. These assessments provide a rich source of information of the quality of each service and this material is used to identify both good practice and areas where improvement is required. It is also used as evidence of compliance with NHSLA and core standards. Actions plan for improvement are agreed with senior nursing staff who conduct the assessments.

In addition the Pharmacy Department has an internal program of audit and also facilitate our participation in the POMH-UK program which provides further assurance of adherence to prescribing to guidelines and implementation of NICE guidance and technology appraisals.
Service line management –
dashboard and care pathways

Service line management is the devolution of management responsibilities to senior clinicians working in an operational service defined by a specific care group i.e. addictions services. Service line management is being piloted in older adults services, addictions and Southwark in-patient services. Two projects which have underpinned the development of service line management are quality dashboards and care pathways.

Quality dashboards pull together information for each service on a number of indicators [including complaints, incidents, patient experience feedback, completion of risk screens and outcome scores] to provide at a glance information which can be used to identify variations to expected performance.

Care pathways provide a clear map of the journey a patient with defined needs should take through a service, with care events and interventions clear mapped. Data on the actual pathway taken by patients can then be applied to identify variance from the expected pathway.

Priorities for 2009/10
01. Patient safety

There are many aspects of patient safety that we actively manage. These include; violence and aggression, clinical risk, health and safety on Trust premises, meeting basic care needs, self harm and suicide risk, and the risk of exploitation of vulnerable people. The approach to all of these patient safety risks is subject to close scrutiny and continuous improvement, all areas have lead committees and lead individuals who are responsible for providing assurances to the Board that controls are in place and standards of quality are achieved and maintained.

Our patient safety priority for 2009/2010 will be to reduce the number of untoward incidents involving the prescribing, dispensing and administration of medication. Although the rate of reported medication incidents has been comparable with other Trusts, we recognise that medication transaction error can have catastrophic effects for individuals, and is preventable.

In 2009/2010 we will:
— introduce electronic prescribing.
A pilot is planned for summer 2009, and full roll-out is anticipated in 2010/2011. E-prescribing reduces the risk of error by reducing ambiguity and transactional error. Each patient will be registered on the system and their entire prescribing history will be available to clinicians
— participate in the Healthcare Foundation patient safety programme focussing on a safe medication administration workstream in our Southwark services
— resolve the problem of medication reconciliation. The Trust has approved a plan to address the problem of medicines reconciliation, with a recommendation that pharmacy be responsible for this task. Individual directorates are required to provide the necessary funding for implementation of the plan
— collate and analyse all medication error data quarterly for the Medicines Management Committee (MMC), Clinical Risk Committee and pharmacy review. Examples and themes of errors are presented to the MMC and any necessary recommendations made and actions monitored
— implement all relevant National Patient Safety Agency (NPSA) pharmaceutical alert bulletins
— continue to participate in the POMH-UK prescribing audits.

02. Patient experience

The experience and satisfaction of people who use our services and their carers is central to our approach to quality measurement. We recognise that a range of different approaches are required appropriate to the different services across SLaM and the communication abilities of people who use these services. The most important thing about collecting feedback is that we listen to it, reflect upon it and do something with it.

In 2009/2010 we will develop our Patient Experience Data Intelligence Centre (PEDIC). PEDIC is a web-based tool that provides us with a central online reporting centre analysing all of the external and internal service user surveys undertaken within SLaM. The main purpose of the PEDIC is to ensure a consistent approach to capturing, inputting and analysing patient experience/satisfaction data. The PEDIC system is centrally managed, will incorporate data from all current electronic (handheld and online as
We recognise that the ability to measure the outcome of the care and treatment delivered by Trust services is vital in order to demonstrate the quality of our service to services users, commissioners of services, clinicians and service managers. Outcome measures are a crucial component to service quality to enable comparisons to be made of similar teams and services in order that variance can be addressed and improvements made. Outcome data will also be critical to the success of future commissioning systems of payment by results or outcome. The ability to link information on diagnosis, treatment and outcome will support our work to ensure that service users receive the best evidence based care as prescribed by the National Institute for Clinical Effectiveness [NICE] clinical guidelines.

Our clinical effectiveness priority in 2009/2010 will be to focus on the collection and use of outcome measures across all services. We will:

- work to embed the recording of outcome measures in all services and increase the percentages of collection, in services where routine collection is established
- focus on the use and analysis of outcome measures to enhance clinical practice, in reflective practice and clinical team meetings. Using analysis to enhance effective practice and discard ineffective practice
- establish the use the CGAS outcome measure within CAMHS at assessment, discharge and six monthly intervals where appropriate.
— develop the programme of CORE-OM data analysis and feedback reports to each service, and develop our ability to benchmark internally, comparing the results of different services. This will support services to make changes on the basis of analysis of factors that might result in different outcomes — encourage the sharing of outcomes data with stakeholders — work in conjunction with designers of the next version of the clinical record system PJS-4 to ensure that as far as possible the system has the facility to be able to collect data which can link diagnosis, treatment and outcome.

Service quality and safety improvement programme
We have agreed four broad areas of quality improvement with the local PCTs who commission services from us. These are:

Patient safety
— Reduce the wide-ranging health risks associated with smoking and reduce health inequalities associated with differential smoking rates between socio-economic groups.

Patient experience
— Improve patient satisfaction levels with regard to SLaM services
— Ensure that disability, sexual orientation, race, ethnicity, gender, age, religion, socio-economic class does not hinder users being able to access and benefit from services. And to ensure that all service users accessing services receive equitable treatment

Outcome measures
— Promote and monitor a recovery model within all services. In particular to manage and monitor delayed discharges.

Service developments
— Ensure compliance with a stepped care model for National Institute for Clinical Excellence (NICE) guidance in the areas of common mental illness, notably anxiety depression and obsessive compulsive disorder, and to particularly focus on the needs of offenders.

Patient safety indicators
PS1. Comparison between incidents of different grades of severity. ['A' grade incidents are the most serious, 'E' grade incidents the least serious].

All Incidents by Financial Year and Grade

<table>
<thead>
<tr>
<th>Year</th>
<th>A</th>
<th>B</th>
<th>C</th>
<th>D</th>
<th>E</th>
</tr>
</thead>
<tbody>
<tr>
<td>04/05</td>
<td>3746</td>
<td>4844</td>
<td>5895</td>
<td>5963</td>
<td>253</td>
</tr>
<tr>
<td>05/06</td>
<td>5344</td>
<td>4254</td>
<td>5577</td>
<td>5051</td>
<td>268</td>
</tr>
<tr>
<td>06/07</td>
<td>5963</td>
<td>4364</td>
<td>766</td>
<td>5344</td>
<td>110</td>
</tr>
<tr>
<td>07/08</td>
<td>5051</td>
<td>4382</td>
<td>909</td>
<td>4844</td>
<td>268</td>
</tr>
<tr>
<td>08/09</td>
<td>3872</td>
<td>4174</td>
<td>1208</td>
<td>4382</td>
<td>268</td>
</tr>
</tbody>
</table>
Quality report

All reported Incidents by Financial Year and Severity Grade

<table>
<thead>
<tr>
<th>Year</th>
<th>A</th>
<th>B</th>
<th>C</th>
<th>D</th>
<th>E</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>04/05</td>
<td>253</td>
<td>110</td>
<td>336</td>
<td>4844</td>
<td>3746</td>
<td>9289</td>
</tr>
<tr>
<td>05/06</td>
<td>268</td>
<td>77</td>
<td>463</td>
<td>4254</td>
<td>5344</td>
<td>10406</td>
</tr>
<tr>
<td>06/07</td>
<td>277</td>
<td>80</td>
<td>766</td>
<td>4364</td>
<td>5963</td>
<td>11450</td>
</tr>
<tr>
<td>07/08</td>
<td>318</td>
<td>81</td>
<td>909</td>
<td>4382</td>
<td>5051</td>
<td>10741</td>
</tr>
<tr>
<td>08/09</td>
<td>383</td>
<td>80</td>
<td>1208</td>
<td>4174</td>
<td>3872</td>
<td>9717</td>
</tr>
<tr>
<td>Totals</td>
<td>1499</td>
<td>428</td>
<td>3682</td>
<td>22018</td>
<td>23976</td>
<td>51603</td>
</tr>
</tbody>
</table>

Factors which should be taken into account when considering the fluctuations in incident reporting rates include:

- a stronger system and culture of incident management
- changes in reporting incentives i.e. visible management action taken as a result of reporting incidents
- effects of policy change
- increased awareness of risks and hazards locally and nationally
- changes to clinical services including new developments.

The increase in the A grade incidents in 2007/08/09 is largely due to better reporting of deaths (due to natural causes) of patients in the community. The increase in ‘C’ grade incidents has been directly proportional to the rate of reporting on-line. Staff who report incidents on-line are responsible for grading them. The fall in ‘D’ and ‘E’ incidents is partly due to fewer reported incidents of violence and aggression.

PS2. Number of RIDDOR* reported incidents as a result of violence.

<table>
<thead>
<tr>
<th>Year</th>
<th>2007/08</th>
<th>2008/09</th>
</tr>
</thead>
<tbody>
<tr>
<td>Number</td>
<td>81</td>
<td>71</td>
</tr>
</tbody>
</table>

*RIDDORs are incidents of defined outcome in terms of injury, which are required to be reported to the Health and Safety Executive under the ‘reporting of injuries deaths and dangerous occurrences regulations’.

PS3. Number of reported medication prescribing/administration incidents [all grades of severity].

<table>
<thead>
<tr>
<th>Year</th>
<th>2007/08</th>
<th>2008/09</th>
</tr>
</thead>
<tbody>
<tr>
<td>Number</td>
<td>519</td>
<td>501</td>
</tr>
</tbody>
</table>
Grades [severity] of reported medication incidents in 2008/2009

<table>
<thead>
<tr>
<th>E</th>
<th>D</th>
<th>C</th>
<th>B</th>
<th>A</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>126</td>
<td>102</td>
<td>272</td>
<td>0</td>
<td>1</td>
<td>501</td>
</tr>
</tbody>
</table>

Patient experience indicators
The survey analysis below based on:
— 537 completed SLaM questionnaires in the 2008 national patient survey
— 1938 completed questionnaires in the additional survey conducted by SLaM – referred to as 2008 SLaM survey in the table below

The table also shows the five core questions - developed with the involvement of service users and clinical staff – that we plan to include within all future SLaM surveys.

<table>
<thead>
<tr>
<th>Core questions developed for use within future SLaM surveys</th>
<th>National and SLaM survey questions</th>
<th>SLaM results</th>
<th>All mental health trust responses</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. How well was your treatment explained to you?</td>
<td>2008 SLaM survey</td>
<td>2008 SLaM survey</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Did the person you saw tell you what was happening with your treatment in a way you could understand?</td>
<td>57% Yes definitely</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>29% Yes to some extent</td>
<td></td>
</tr>
<tr>
<td>2008 national patient survey</td>
<td>2008 SLaM national patient survey result</td>
<td>2008 mental health trust average</td>
<td></td>
</tr>
<tr>
<td>Were you given enough time to discuss your condition and treatment?</td>
<td>63% Yes definitely</td>
<td>68% Yes definitely</td>
<td></td>
</tr>
<tr>
<td></td>
<td>25% Yes to some extent</td>
<td>23% Yes to some extent</td>
<td></td>
</tr>
</tbody>
</table>
## Quality report —

<table>
<thead>
<tr>
<th>Core questions developed for use within future SLaM surveys</th>
<th>National and SLaM survey questions</th>
<th>SLaM results</th>
<th>All mental health trust responses</th>
</tr>
</thead>
<tbody>
<tr>
<td>2. How successful is the staff team in helping you to achieve what you want in your life?</td>
<td>2008 national patient survey</td>
<td>2008 SLaM national patient survey result</td>
<td>2008 mental health trust average</td>
</tr>
<tr>
<td>In the last 12 months have you received any information about local support groups for mental health service users?</td>
<td>25% Yes</td>
<td>25% Yes</td>
<td>28% Yes</td>
</tr>
<tr>
<td></td>
<td>38% I did not need any information</td>
<td>42% I did not need any information</td>
<td></td>
</tr>
<tr>
<td></td>
<td>2008 national patient survey</td>
<td>2008 SLaM national patient survey result</td>
<td>2008 mental health trust average</td>
</tr>
<tr>
<td>In the last 12 months have you received help with finding work?</td>
<td>14% Yes</td>
<td>14% Yes</td>
<td>9% Yes</td>
</tr>
<tr>
<td></td>
<td>24% I did not need any help</td>
<td>31% I did not need any help</td>
<td></td>
</tr>
<tr>
<td></td>
<td>42% I am unable to work because of my mental health problems</td>
<td>50% I am unable to work because of my mental health problems</td>
<td></td>
</tr>
<tr>
<td></td>
<td>2008 national patient survey</td>
<td>2008 SLaM national patient survey result</td>
<td>2008 mental health trust average</td>
</tr>
<tr>
<td>In the last 12 months have you received help with getting benefits (e.g. Housing Benefit, Attendance Allowance)?</td>
<td>42% Yes</td>
<td>42% Yes</td>
<td>40% Yes</td>
</tr>
<tr>
<td></td>
<td>38% I did not need any help</td>
<td>44% I did not need any help</td>
<td></td>
</tr>
</tbody>
</table>

3. How well does the environment of the building meet your needs?

| N/A | N/A | N/A |

> 64/100
### Core questions developed for use within future SLaM surveys

<table>
<thead>
<tr>
<th>Question</th>
<th>National survey</th>
<th>SLaM survey</th>
<th>All mental health trust responses</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>4. How well do you trust the people providing you your care?</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2008 national patient survey</td>
<td>2008 SLaM national patient survey result</td>
<td>2008 mental health trust average</td>
<td></td>
</tr>
<tr>
<td>Did you have trust and confidence in the psychiatrist you saw?</td>
<td>60% Yes definitely 28% Yes to some extent</td>
<td>64% Yes definitely 28% Yes to some extent</td>
<td></td>
</tr>
<tr>
<td><strong>2008 national patient survey</strong></td>
<td><strong>2008 SLaM national patient survey result</strong></td>
<td><strong>2008 mental health trust average</strong></td>
<td></td>
</tr>
<tr>
<td>Did you have trust and confidence in the CPN?</td>
<td>62% Yes definitely 28% Yes to some extent</td>
<td>76% Yes definitely 18% Yes to some extent</td>
<td></td>
</tr>
<tr>
<td><strong>2008 SLaM survey</strong></td>
<td><strong>2008 SLaM survey</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Did you have trust and confidence in the person you saw last?</td>
<td>63% Yes definitely 28% Yes to some extent</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>5. How well have staff listened to you today?</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2008 national patient survey</td>
<td>2008 SLaM national patient survey result</td>
<td>2008 mental health trust average</td>
<td></td>
</tr>
<tr>
<td>Did the psychiatrist listen carefully to you?</td>
<td>71% Yes definitely 25% Yes to some extent</td>
<td>74% Yes definitely 23% Yes to some extent</td>
<td></td>
</tr>
<tr>
<td><strong>2008 national patient survey</strong></td>
<td><strong>2008 SLaM national patient survey result</strong></td>
<td><strong>2008 mental health trust average</strong></td>
<td></td>
</tr>
<tr>
<td>Did the CPN listen carefully to you?</td>
<td>71% Yes definitely 23% Yes to some extent</td>
<td>82% Yes definitely 14% Yes to some extent</td>
<td></td>
</tr>
<tr>
<td><strong>2008 national patient survey</strong></td>
<td><strong>2008 SLaM national patient survey result</strong></td>
<td><strong>2008 mental health trust average</strong></td>
<td></td>
</tr>
<tr>
<td>Did the person (last person seen other than a psychiatrist or CPN) listen carefully to you?</td>
<td>73% Yes definitely 22% Yes to some extent</td>
<td>80% Yes definitely 6% Yes to some extent</td>
<td></td>
</tr>
</tbody>
</table>
The data below is sourced from the Department of Health Patient Experience First Steps Diagnostic Tool which provides a London / England comparison across four domains (and an overall score) from the 2008 national mental health patient survey.

<table>
<thead>
<tr>
<th>Access and waiting</th>
<th>SLaM score</th>
<th>England average</th>
<th>London average</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>78</td>
<td>80</td>
<td>80</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Safe, high quality, coordinated care</th>
<th>SLaM score</th>
<th>England average</th>
<th>London average</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>66</td>
<td>72</td>
<td>71</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Better information, more information</th>
<th>SLaM score</th>
<th>England average</th>
<th>London average</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>57</td>
<td>62</td>
<td>62</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Building relationships</th>
<th>SLaM score</th>
<th>England average</th>
<th>London average</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>86</td>
<td>87</td>
<td>87</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Overall</th>
<th>SLaM score</th>
<th>England average</th>
<th>London average</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>72</td>
<td>76</td>
<td>75</td>
</tr>
</tbody>
</table>

We implemented a number of actions to address issues highlighted in the national survey. Areas of improvement indicated by the larger SLaM survey which took place later in the year are highlighted on the right. The analysis is based on the scoring system used by the Healthcare Commission in which response choices are attributed with a weighting (e.g. Yes = 100; No=0). The scores therefore reflect on a given domain out of 100, and do not denote the percentage of respondents who feel a particular way.

<table>
<thead>
<tr>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Provision of care plans</td>
<td>41</td>
</tr>
<tr>
<td>Assigned care co-ordinator</td>
<td>66</td>
</tr>
<tr>
<td>Had care review</td>
<td>56</td>
</tr>
<tr>
<td>Provided with out of hours contact details</td>
<td>38</td>
</tr>
<tr>
<td>Had enough say in care and treatment decisions</td>
<td>58</td>
</tr>
</tbody>
</table>
Clinical effectiveness indicators
CE1. Patients with paired HoNOS scores completed.

Outcomes: Paired HonOS Ratings – Trust

<table>
<thead>
<tr>
<th>Month</th>
<th>Jan</th>
<th>Feb</th>
<th>Mar</th>
<th>Apr</th>
<th>May</th>
<th>Jun</th>
<th>Jul</th>
<th>Aug</th>
<th>Sep</th>
<th>Oct</th>
<th>Nov</th>
<th>Dec</th>
</tr>
</thead>
<tbody>
<tr>
<td>% Paired HoNOS</td>
<td>15.5%</td>
<td>17.0%</td>
<td>18.2%</td>
<td>19.7%</td>
<td>21.1%</td>
<td>22.2%</td>
<td>24.1%</td>
<td>25.4%</td>
<td>27.3%</td>
<td>28.1%</td>
<td>29.6%</td>
<td>30.7%</td>
</tr>
<tr>
<td>Target</td>
<td>50.6%</td>
<td>50.6%</td>
<td>50.6%</td>
<td>50.6%</td>
<td>50.6%</td>
<td>50.6%</td>
<td>50.6%</td>
<td>50.6%</td>
<td>50.6%</td>
<td>50.6%</td>
<td>50.6%</td>
<td>50.6%</td>
</tr>
<tr>
<td>Variance</td>
<td>-24.1%</td>
<td>-33.8%</td>
<td>-32.4%</td>
<td>-20.8%</td>
<td>-29.6%</td>
<td>-28.4%</td>
<td>-28.5%</td>
<td>-26.2%</td>
<td>-23.8%</td>
<td>-22.5%</td>
<td>-21.0%</td>
<td>-19.9%</td>
</tr>
</tbody>
</table>

% Patients with Paired HoNOS Ratings

CE2. Outcome scores following completion of a course of psychological treatment.

CORE-OM Outcomes Analysis
As of 20/01/2009, for working age adults, across the 4 borough directorates, 3834 individuals had at least one CORE-OM entered onto PJS, and 903 individuals provided paired ratings (a CORE-OM at pre and post therapy). 47% of these clients demonstrated statistically reliable improvement between their pre and post CORE-OM global distress scores.

For older adults [65 and over], 833 individuals had at least one CORE-OM entered onto EPJs, and 247 individuals provided paired ratings.
Quality report

Table 1 – Mean Global Distress Scores, Pre and Post Treatment

|                        | Pre Treatment Global Distress Score | Post Treatment Global Distress Score | Effect Size
|------------------------|-------------------------------------|--------------------------------------|--------------
| Working Age Adults N = 902 | 1.86 (SD 0.73)                      | 1.31 (SD 0.76)                       | 0.72         
| Older Adults N = 247    | 1.39 (SD 0.58)                      | 0.93 (SD 0.53)                       | 0.87         

An effect size is a standard way of reporting significant treatment effects (which takes account of the variability occurring naturally in the population) – there are conventions for determining effect size (0.2 and above is indicative of a small effect, 0.5 a medium and 0.8 a large effect size (Cohen 1992).

Table 2 – Reliable Change in CORE-OM Global Distress Scores between pre and post treatment

<table>
<thead>
<tr>
<th></th>
<th>Working Age</th>
<th>MHOA</th>
</tr>
</thead>
<tbody>
<tr>
<td>Change</td>
<td>Number</td>
<td>Percent</td>
</tr>
<tr>
<td>Reliable Improvement</td>
<td>426</td>
<td>47.2%</td>
</tr>
<tr>
<td>Non-reliable Improvement</td>
<td>271</td>
<td>30.0%</td>
</tr>
<tr>
<td>Non-reliable deterioration</td>
<td>177</td>
<td>19.6%</td>
</tr>
<tr>
<td>Reliable deterioration</td>
<td>29</td>
<td>3.2%</td>
</tr>
<tr>
<td>Total</td>
<td>903</td>
<td>100%</td>
</tr>
</tbody>
</table>
CE3. Childrens Global Assessment Scale (CGAS)

The Childrens Global Assessment Scale (CGAS) has been developed at the Department of Psychiatry, Columbia University to provide a global measure of level of functioning in children and adolescents. The measure provides a single rating only, on scale of 0–100. This measure is being established in all SLaM child and adolescent mental health services which provide ongoing treatment or therapy.

<table>
<thead>
<tr>
<th></th>
<th>Cases opened in 2008/2009</th>
<th>Closed during 2008/09</th>
<th>Open and closed cases combined</th>
</tr>
</thead>
<tbody>
<tr>
<td>Eligible</td>
<td>3063</td>
<td>4991</td>
<td>8054</td>
</tr>
<tr>
<td>Paired</td>
<td>323</td>
<td>752</td>
<td>1075</td>
</tr>
<tr>
<td>Paired %</td>
<td>11%</td>
<td>15%</td>
<td>13%</td>
</tr>
</tbody>
</table>

A monitoring system for paired CGAS measures will be fully implemented in 2009/10 and this should result in an increase in the level of CGAS scores recorded. The internal CAMHS target for paired CGAS for eligible patients is 50% for 2009/10.
Members’ Council –

The role of the Members’ Council responsibilities – set out in the NHS Bill 2006 (chapter 5) consolidated and updated regulations regarding Foundation Trusts and in the Trust’s constitution – is to:

— support the Board of Directors in setting the longer-term vision for the Trust, to influence proposals to make changes to services and to act in a way that is consistent with NHS principles and values and the terms of the Trust’s authorisation
— engage in dialogue with and provide advice to the Board of Directors regarding the Trust’s future vision and strategy, and to act as a source of ideas about how the Trust can provide its services in ways that meet the needs of the community it serves
— review annually the extent to which the Trust is meeting its objective of delivering high quality services
— work with the Board of Directors on such other matters for the benefit of the Trust as may be agreed between them
— exercise other functions at the request of the Board of Directors
— respond as appropriate when consulted by the Board of Directors
— exercise such other powers and to discharge such other duties as may be conferred on the Members’ Council under the Constitution.

— receiving a presentation of the annual report and accounts at a general meeting.

The Board of Directors has a duty to consult and pay due regard to the views of the Members’ Council in relation to forward planning, particularly in relation to information which is submitted to Monitor.

The Members’ Council is not responsible for the day-to-day running of the organisation. Legislation provides that all the powers of the NHS Foundation Trust are to be exercised by its directors. The Members’ Council cannot therefore veto decisions made by the Board of Directors.

All Directors are invited to attend the meetings of the Members’ Council as a means of both gaining an understanding of the issues being considered and to give immediate responses to questions or issues raised during the course of the meeting. A report of the Members’ Council activity is a standing item on the agenda for the monthly meetings of the Board of Directors. Members of the Members’ Council are able to approach any member of the Board with any questions or concerns they have.
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<th>Section</th>
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</thead>
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</tr>
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<td>Message from the Chair</td>
</tr>
<tr>
<td>15</td>
<td>Message from the Chief Executive</td>
</tr>
<tr>
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<td>In focus</td>
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<td>2008 — 09 Annual Report and Summary Accounts Members’ Council</td>
<td></td>
</tr>
</tbody>
</table>

### Organisation / constituency

<table>
<thead>
<tr>
<th>Appointed members</th>
<th>Name</th>
<th>Term of Office</th>
<th>Meetings attendance</th>
</tr>
</thead>
<tbody>
<tr>
<td>Croydon PCT</td>
<td>Ms Caroline Taylor</td>
<td>3 years</td>
<td>0/4</td>
</tr>
<tr>
<td>Lambeth PCT</td>
<td>Mr Andrew Eyres</td>
<td>3 years</td>
<td>1/4</td>
</tr>
<tr>
<td>Lewisham PCT</td>
<td>Ms Magda Moorey</td>
<td>3 years</td>
<td>1/4</td>
</tr>
<tr>
<td>Southwark PCT</td>
<td>Mr Winston Tayler</td>
<td>3 years</td>
<td>1/4</td>
</tr>
<tr>
<td>National Charity</td>
<td>Ms Sophie Corlett (1)</td>
<td>3 years</td>
<td>2/2</td>
</tr>
<tr>
<td>Croydon Council</td>
<td>Cllr Lindsay Frost</td>
<td>3 years</td>
<td>0/4</td>
</tr>
<tr>
<td>Lambeth Council</td>
<td>Cllr Lorna Campbell</td>
<td>3 years</td>
<td>0/4</td>
</tr>
<tr>
<td>Lewisham Council</td>
<td>Cllr Crada Onuegbu</td>
<td>3 years</td>
<td>2/4</td>
</tr>
<tr>
<td>Southwark Council</td>
<td>Cllr David Noakes (2)</td>
<td>3 years</td>
<td>0/2</td>
</tr>
<tr>
<td>King’s College London</td>
<td>Dr Lynn Carlisle</td>
<td>3 years</td>
<td>1/4</td>
</tr>
<tr>
<td>King’s College Hospital NHSFT</td>
<td>Prof John Moxham</td>
<td>3 years</td>
<td>1/4</td>
</tr>
<tr>
<td>Guy’s and St Thomas’ NHSFT</td>
<td>Mrs Patricia Moberly</td>
<td>3 years</td>
<td>3/4</td>
</tr>
<tr>
<td>NHS London</td>
<td>Ms Dawn Stephenson</td>
<td>3 years</td>
<td>0/4</td>
</tr>
</tbody>
</table>

### Elected members

| Public-London Boroughs of Croydon, Lambeth, Lewisham and Southwark | Mr Noel Urwin (3) | 3 years | 4/4 |
| As above | Ms Michelle Baharier (4) | 3 years | 0/4 |
## Members’ Council

<table>
<thead>
<tr>
<th>Organisation / constituency</th>
<th>Name</th>
<th>Term of Office</th>
<th>Meetings attendance: Attended / Eligible to attend</th>
</tr>
</thead>
<tbody>
<tr>
<td>Appointed members</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>As above</td>
<td>Mr Derrick Bentley (5)</td>
<td>3 years</td>
<td>1/2</td>
</tr>
<tr>
<td>As above</td>
<td>Mr John Muldoon (6)</td>
<td>3 years</td>
<td>4/4</td>
</tr>
<tr>
<td>As above</td>
<td>Ms Stephanie Correia</td>
<td>3 years</td>
<td>4/4</td>
</tr>
<tr>
<td>Staff</td>
<td>Vacant (7)</td>
<td>3 years</td>
<td></td>
</tr>
<tr>
<td>Staff</td>
<td>Dr Dele Olajide</td>
<td>3 years</td>
<td>2/4</td>
</tr>
<tr>
<td>Staff</td>
<td>Dr Francis Keaney (8)</td>
<td>3 years</td>
<td>3/4</td>
</tr>
<tr>
<td>Staff</td>
<td>Ms Gill Todd (9)</td>
<td>3 years</td>
<td>3/4</td>
</tr>
<tr>
<td>Staff</td>
<td>Mr Abbey Akinoshun (10)</td>
<td>3 years</td>
<td>1/2</td>
</tr>
<tr>
<td>Staff</td>
<td>Mr Cliff Bean</td>
<td>3 years</td>
<td>2/4</td>
</tr>
<tr>
<td>SLaM service users</td>
<td>Ms Polly De Blank (11)</td>
<td>3 years</td>
<td>1/2</td>
</tr>
<tr>
<td>within Croydon, Lambeth,</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Lewisham and Southwark</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>As above</td>
<td>Vacant (12)</td>
<td>3 years</td>
<td></td>
</tr>
<tr>
<td>As above</td>
<td>Mr Les Elliot</td>
<td>3 years</td>
<td>3/4</td>
</tr>
<tr>
<td>As above</td>
<td>Ms Paula Crook (13)</td>
<td>3 years</td>
<td>3/4</td>
</tr>
<tr>
<td>As above</td>
<td>Mr Paul Paterson</td>
<td>3 years</td>
<td>4/4</td>
</tr>
<tr>
<td>As above</td>
<td>Ms Kitty-Anne Cooke</td>
<td>3 years</td>
<td>0/4</td>
</tr>
<tr>
<td>Public - rest of England and</td>
<td>Dr Abdul Shakoor</td>
<td>Resigned Dec 2008</td>
<td>0/2</td>
</tr>
<tr>
<td>Wales</td>
<td>Ms Omolade Oshunremi</td>
<td>Resigned Dec 2008</td>
<td>2/3</td>
</tr>
</tbody>
</table>
Members’ Council

As above

Carers of SLaM service users

Mr Roger Oliver

3 years

3/4

As above

Ms Jaya Kathrecha

3 years

2/4

Service users - outside of Croydon, Lambeth, Southwark and Lewisham

Mrs Amanda Easton

3 years

0/4

As above

Mr Didier Lusala Mavinga

Removed Sep 2008

0/2

As above

Vacant

3 years

Carers of SLaM service users

Vacant

3 years

(1) Replaced Paul Farmer September 2008
(2) From June 2008
(3) Re-elected October 2008
(4) Re-elected October 2008
(5) Elected October 2008, replacing Rachael Collins
(6) Re-elected October 2008
(7) Peter Hayward to October 2008
(8) Re-elected October 2008
(9) Re-elected October 2008
(10) Elected October 2008, replacing Siobhan Netherwood
(11) Elected October 2008, replacing Aloyse Raptopoulos
(12) George Tagg to February 2009
(13) Re-elected October 2008

Nominations Committee

The Nominations Committee is appointed and authorised by the Members’ Council. The Committee is responsible for the selection and reappointment process for Non Executives; receiving reports on behalf of the Members’ Council regarding the outcome of appraisals or the Chair and Chief Executive; providing advice to the Members’ Council on remuneration and allowances for the Chair and Non Executive Directors; and reviewing the skill mix of the Board of Directors.

Members

Madeliene Long Chair
Patricia Moberly Guy’s and St Thomas’ NHS FT
John Muldoon Public - Local
Noel Urwin Public - Local
Paul Paterson (1) Service User - Local
Dr Dele Olajide Staff

(1) Aloyse Raptopoulos to June 2008
The Nominations Committee met on 5th June 2008 (apologies from Aloyse Raptopoulos) and 12th March 2009 (attended by all members).
Board of Directors

Meetings

<table>
<thead>
<tr>
<th>Name</th>
<th>Board meetings 11 held in 2008/09</th>
<th>Remuneration Committee Attended / Eligible to attend</th>
<th>Audit Committee Attended / Eligible to attend***</th>
</tr>
</thead>
<tbody>
<tr>
<td>Madeliene Long *</td>
<td>11</td>
<td>2/2</td>
<td>■</td>
</tr>
<tr>
<td>Martin Baggaley</td>
<td>8</td>
<td>■</td>
<td>■</td>
</tr>
<tr>
<td>Stuart Bell</td>
<td>11</td>
<td>■</td>
<td>■</td>
</tr>
<tr>
<td>Chris Clare</td>
<td>8</td>
<td>■</td>
<td>■</td>
</tr>
<tr>
<td>Robert Coomber **</td>
<td>9</td>
<td>■</td>
<td>6/6</td>
</tr>
<tr>
<td>Patricia Connell-Julien</td>
<td>10</td>
<td>■</td>
<td>■</td>
</tr>
<tr>
<td>Harriet Hall</td>
<td>10</td>
<td>2/2</td>
<td>■</td>
</tr>
<tr>
<td>Gus Heafield</td>
<td>10</td>
<td>■</td>
<td>■</td>
</tr>
<tr>
<td>Kumar Jacob</td>
<td>7</td>
<td>2/2</td>
<td>6/6</td>
</tr>
<tr>
<td>Hilary McCallion</td>
<td>10</td>
<td>■</td>
<td>■</td>
</tr>
<tr>
<td>Zoë Reed</td>
<td>10</td>
<td>■</td>
<td>■</td>
</tr>
<tr>
<td>Eric Taylor</td>
<td>9</td>
<td>■</td>
<td>2/4</td>
</tr>
</tbody>
</table>

Not a member of the committee

* Chair of the Remuneration Committee
** Chair of the Audit Committee
*** Of the 6 meetings held, one was an accounts review and another was an estates strategy review
About the Board of Directors —
Non Executive Directors

> Madeliene Long
(Chair)


Madeliene Long is a Barrister with experience in both civil and criminal law. She was called to the Bar in 1999 following a first career in social work education and training. Until 1997 she was Head of the Department of Social Work at the Mid-Kent College of Higher and Further Education. She has postgraduate qualifications in law and management and was an External Academic Examiner to the Masters Programme in Social Work at the University of Kent. Madeliene is also an Elected Member of Lewisham Council and was the Chair of the first Lewisham Joint Committee of Health and Social Services. She was actively involved in the early joint initiatives in services for people with learning difficulties. Madeliene has spent over 20 years in the public service, having held senior Council positions as Cabinet member for Resources and Finance, and Chair of the Social Services, and Personnel Committees. She has a keen interest in health and social care issues and public sector employment relations. Madeliene was a Non-Executive Director at Lewisham and Guy’s NHS Trust before being appointed as the first Chair of South London and Maudsley NHS Trust. Madeliene has led the Trust into Foundation Trust authorisation in November 2006 and has recently been reappointed as Chair by the Members’ Council. She has recently chaired the Partnership Board of Kings Health Partners during the AHSC accreditation process.
Robert Coomber

Appointed May 2007 – June 2010
Bob Coomber joined SLaM in 2007, having left Southwark Council in June 2006 after twelve years as their Chief Executive and a similar period as Director of Finance. At Southwark Bob was instrumental in driving much of the improvement and regeneration that has taken place in recent years which can be seen in Peckham and Bermondsey. Southwark was also one of the first authorities to attempt to integrate its social care function with that of the local PCT. In all Bob has spent more than thirty five years in London local government and has extensive experience of working with public service organisations to improve local public services like health, community safety, education and housing. Bob lives in the borough of Lewisham and has two grown up daughters one of whom is training to be a physiotherapist.

Dr Patricia Connell–Julien

Re-appointed June 2008 until June 2011
Dr Patricia Connell–Julien has a Sociology background, with a PhD in Criminology, and has worked as a researcher for over ten years. Patricia has an interest in social and health-care issues. She has project-managed and conducted research with residents of South London, and has co-authored a number of publications about young people and sexual health, and on stroke services. She has recently co-evaluated the modernisation of local healthcare services. Patricia has previous experience in Social Welfare, and managerial experience in commercial banking. In a voluntary capacity, Patricia has been a Board Member of a local Housing Association for several years, and is a Trustee of a local Charity providing services to people with mental health needs and people with learning difficulties. Patricia’s Board responsibilities include Chairing the Trust-wide Mental Health Act Committee, and membership of the Patient Safety and Service Improvement Committee, and the Charitable Funds Grants Committee.

Chris Clare

Appointed Jan 2008 – Dec 2010
Professor Chris Clare’s background is in both information systems and technology, and management. He graduated in mathematics and statistics from the University of London and joined British Telecom as a programmer/systems analyst. He moved on to become head of a management services group undertaking various projects within BT. From there he joined the (then) South Bank Polytechnic as a lecturer in computing. During his time at South Bank, he became Head of Computing and Mathematics and, as it became a university, was appointed Director of strategic planning and management information.

In the mid 1990s Chris was appointed Dean of Engineering, Science and Technology and Professor of information systems. Following a major restructure, he became Dean of a new faculty of business and computing, being responsible for 250 staff and 4,000 students. He retired from London South Bank University in 2007. As well as his work with the Trust, he has a part time role with the body that audits and reviews universities in the UK and has returned to some teaching with the Open University.
Harriet Hall qualified as a solicitor in 1976 and first worked in private practice and later as legal officer for the National Consumer Council from 1991 to 2000. More recently she was a member of the Financial Services Consumer Panel, representing the interests of retail customers of financial services companies to regulators. As a freelance researcher and writer, she has been involved in several projects developing consumer/user policy in fields including pensions and data use and privacy. She is a non executive director of C & J Clark Ltd, the shoe company, where she sits on the Appointments and Remuneration Committee and Audit Committee. She lives in Lambeth and has been a member of a number of management committees for local voluntary organisations.

Kumar Jacob is Director of KJLearning Limited, a consultancy specialising in training and performance within the computer games industry. He completed his MBA at Cranfield University School of Management. He is a Trustee and member of the board of directors of Christian Aid. Kumar has been involved in local political activities on behalf of the Labour Party. He chairs the South London and Maudsley NHS Foundation Trust Charitable Funds.

Professor Eric Taylor, M.B. is Emeritus Professor of Child and Adolescent Psychiatry at King’s College, London Institute of Psychiatry. He has previously been engaged in research in hyperactivity and other neuropsychiatric conditions (for which he was awarded the Ruane Prize) and in clinical work at the Maudsley Hospital with a neuropsychiatry specialization and lead clinician responsibility for the child outpatient teams at the Maudsley. He is a Trustee of the National Academy of Parenting Practitioners, chairs the Paediatric Psychopharmacology Group, the Association for Child and Adolescent Mental Health, and a Guidelines Development Group for the National Institute of Clinical Excellence. He has previously been a Head of Department at King’s College London, Chair of the Child Psychiatry research Society, Vice-Dean and Deputy Registrar of the Royal College of Psychiatrists, and a Trustee of the Psychiatry Research Trust. He is a Fellow of the Royal College of Physicians, and the Academy of Medical Sciences. He has been involved for a long time with user groups in child mental health, especially ADDISS (Attention Deficit Disorder Information Services).
About the Board of Directors

Executive Directors

and chaired Southwark Association for Mental Health and a community development project for families with a member with severe learning difficulties.

Dr Martin Baggaley
Medical Director

Stuart Bell, CBE
Chief Executive

Martin Baggaley is the Medical Director of the Trust and lead for Clinical Governance. He joined Lewisham and Guy's Mental Health Trust in 1997 as a consultant psychiatrist based in Lewisham East. He then became clinical director for Lewisham adult mental health services in 1999. He has always been interested in informatics and carried out a two-year secondment with Connecting for Health. He is interested in Post-Traumatic Stress Disorder and provides a clinical service based at Guy's Hospital for individuals with psychosexual problems.

Stuart Bell joined the NHS in 1982 after graduating from Oxford University. He worked at Charing Cross and the Whittington Hospitals and then moved to South West Thames Regional Health Authority in 1990. In 1996 he was seconded to the NHS headquarters as Head of Performance Management for England. Since then he has been Chief Executive of Thameslink NHS Trust and Lewisham and Guy's Mental Health NHS Trust. Stuart was awarded a CBE in 2008 for services to the NHS.

The Register of Interests for the Board of Directors can be obtained from the Chair's Office tel: 020 3228 4763
Gus Heafield is a Chartered Accountant. He joined the Bethlem and Maudsley NHS Trust in 1996 as Director of Finance and Information and was appointed to his current post when SLaM was formed in 1999. An Oxford chemistry graduate, Gus trained as a chartered accountant at Touche Ross working on a number of high profile plc audits as well as consultancy assignments. He joined the NHS 19 years ago as a consultant to the NHS Management Executive Trust Unit establishing the financial monitoring regime for the then newly created NHS Trusts. Following this, he spent three years as Assistant Director at South Thames Regional Office assessing and performance managing NHS Trusts in south London. His role at SLaM includes providing financial and governance advice to the Board and providing professional leadership for the finance and corporate governance and IT functions, ensuring high standards of integrated financial planning and probity. He also manages the development and implementation of the Trust’s Integrated Governance framework.

Hilary McCallion is responsible for clinical quality standards, patient safety and education and training. She is responsible for the professional leadership of nurses and nursing across the organization, ensuring professional standards are set and maintained. Hilary has worked across England and Wales in education and clinical practice and has both general and psychiatric nursing experience. She has been a recipient of the Florence Nightingale Award for the examination of people with AIDS related brain impairment. She is visiting professor at London South Bank University and Nightingale School, Kings College, London. She is Chair of the Mental Health and Learning Disabilities Director of Nursing and Lead Nurses National forum. During 2008 Hilary took on management responsibility for hotel services.

Zoë Reed is the Executive Director for Strategy and Business Development, with responsibility for developing and articulating the organisation's strategic goals, and ensuring that it works in partnership with others to achieve them; building a picture of internal performance and the external market, and identifying how the Trust improves its position from the base of ensuring compliance with the Terms of Authorization; promoting organisational growth, development and innovation to ensure delivery of the Trust’s Strategy and Business Development. Zoë’s last local authority role was as Corporate Director Partnership and Citizen Engagement. Zoë has a wide-ranging experience of service management – from the provision of cleaning, catering and other support services for a London Local Authority through to establishing joint commissioning and strategic planning functions for a Social Services Department.
Membership —
Reasons to become a member of SLaM

● Help us put mental health on the map. In the past, mental health services have sometimes been seen as the poor relation to other parts of the NHS. If you believe that mental health services are important, then we hope you will say so by joining up.

● Put yourself forward for election.
As a member, you can stand in the elections for our Members’ Council, which has a statutory role in overseeing the organisation’s strategic direction. There are seats on the Members’ Council for individual staff, service users, carers and public.

● Sign up and have a vote.
You need to be a member in order to have a vote in deciding who sits on our Members’ Council.

● Help determine our priorities.
We believe we have a good track record of seeking to involve people in decisions about the future of services. Membership takes this to another level. As an NHS Foundation Trust, our Board of Directors has a statutory responsibility to take account of the views of the Members’ Council on issues such as determining our priorities for the future. As a member, you decide who sits on the Council.

● Add your weight to the voice of SLaM membership.
Membership provides an opportunity for service users, carers, health and social care professionals to come together and create a powerful voice to lobby for informed public debate about mental health issues. You don’t need to agree with everything the Trust does in order to become a member – the only ‘party line’ we ask you to share is a belief in the rights of people with mental health problems to receive dignity, respect and effective care and treatment.

● Help us make the most of membership.
The concept of membership is still evolving at SLaM. By becoming a member, you have an opportunity to influence this. How do you think we can make the most of membership?

● Make us truly representative.
Mental health and well-being is an issue for everyone. We need a broad range of opinion to help us make the best possible decisions about how we provide healthcare. So, for example, we believe it is important that our membership isn’t just made up of health and social care professionals. We also need to ensure that other groups have a voice – including service users, carers and public.

### Membership recruitment

<table>
<thead>
<tr>
<th>Constituency</th>
<th>March 08</th>
<th>March 09</th>
<th>Annual increase (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Public</td>
<td>1,071</td>
<td>1,953</td>
<td>82.4</td>
</tr>
<tr>
<td>Service User</td>
<td>701</td>
<td>724</td>
<td>3.3</td>
</tr>
<tr>
<td>Carer</td>
<td>215</td>
<td>229</td>
<td>6.5</td>
</tr>
<tr>
<td>Staff</td>
<td>2,307</td>
<td>4,740</td>
<td>105.4</td>
</tr>
<tr>
<td>Total</td>
<td>4,294</td>
<td>7,646</td>
<td>78.1</td>
</tr>
</tbody>
</table>

> 80/100
Anyone who lives in England and Wales can join the Trust as a public member.

Anyone who is employed by the Trust under a contract of employment may become or continue as a staff member provided they:

1. are employed by the Trust under a contract of employment which has no fixed term or has a fixed term of at least 12 months
2. have been continuously employed by the Trust under a contract of employment for at least 12 months
3. Individuals who exercise functions for the purposes of the Trust, otherwise than under a contract of employment with the Trust may become or continue as members of the staff constituency provided such individuals have exercised these functions continuously for a period of at least 12 months
4. Anyone whose name is recorded as a patient on the Trust’s patient administration system or other record maintained for the purpose of identifying patients of the Trust and who has, within the last five years, attended the Trust as a patient can join as a member of the service user constituency.
5. Anyone who has within the last five years, attended the Trust as the carer of a patient, may become or continue as a member of the Trust in the carer constituency.

Our revised membership strategy “Membership Plus” was agreed by the Members’ Council in June 2008. This included a three year plan to increase the membership base of the Foundation Trust to 12,000 members by March 2011 (which we are on target to meet).

An example of our membership engagement programme is our ‘can money buy you happiness’ campaign in which we invited applicants to submit a bid that would improve the patient experience, promote mental well-being or increase social inclusion. 75 small funding grants were allocated as a result of the process. The funding was used to support a wide variety of initiatives including music lessons for service users and carers within one of our community services, yoga sessions and poetry workshops. We are running a similar campaign this year. To help improve communication with our members during 2009 we are planning to re-launch our website and newsletter on mental health issues.
Public interest disclosures

Health and safety
The Health and Safety Executive visited SLaM in November 2008 to follow up on incidents that had been reported under the Reporting of Injuries and Dangerous Occurrences Regulations. The Inspector was satisfied with our approach in dealing with these incidents.

South Coast Audit carried out an Audit of the Trust Safety Management Systems in November/December 2008 and the report gives significant assurance to the Trust Board that a robust management systems for health and safety is in place.

Occupational health
The sickness level for 2008/09 was 7.3%, compared to 7.6% the previous year. Four employees retired on the grounds of ill health within the last year. One of the ways we are looking to support staff is by providing rapid access to treatment for people who develop mental health problems. SLaM Trustees have allocated a grant to develop a new service which will be launched in the coming year as a 2 year pilot.

Countering fraud and corruption
As well as following national guidance, we have a range of procedures in place including Standing Orders and Standing Financial Instructions which are designed to minimise the likelihood of the Trust being a victim of fraud.

Our Counter Fraud and Whistleblowing Policies encourage and enable staff to voice genuinely held concerns. The policies – which have been reviewed and updated – are designed to ensure that staff feel able to report suspicions of fraud without fear of repercussions.

We have two dedicated Local Counter Fraud Specialists working within the Trust. They carry out a range of work including investigating reported suspicions of fraud. More importantly they also carry out proactive work to prevent and deter fraud from occurring in the first place.

Consultation
We hold annual briefing sessions with our four local Overview and Scrutiny Committees (OSCs) within Croydon, Lambeth, Lewisham and Southwark on the Annual Health Check for Standards for Better Health. We have also engaged with local OSCs on specific clinical service changes.

We also attend local OSCs on request to provide a broader overview of service provision within local Borough services.

Better payments practice code
‘Better Payment Practice Code is a target of paying 95% of bills within contract terms or 30 days where no terms have been agreed. The Code requires the Trust to aim to pay undisputed invoices by the due date or within 30 days of receipt of goods or a valid invoice, whichever is later. We paid 98% of invoices within this period (95% in terms of value).
Statement of the Chief Executive’s responsibilities —
as the Accounting Officer of South London and Maudsley NHS Foundation Trust

The National Health Service Act 2006 states that the Chief Executive is the Accounting Officer of the South London and Maudsley NHS Foundation Trust. The relevant responsibilities of accounting officer, including their responsibility for the propriety and regularity of public finances for which they are answerable, and for the keeping of proper accounts, are set out in the Accounting Officers’ Memorandum issued by the Independent Regulator of NHS Foundation Trusts (“Monitor”).

Under the National Health Service Act 2006, Monitor has directed the South London and Maudsley NHS Foundation Trust to prepare for each financial year a Statement of Accounts in the form and on the basis set out in the Accounts Direction. The Accounts are prepared on an accruals basis and must give a true and fair view of the state of affairs of South London and Maudsley NHS Foundation Trust and of its income and expenditure, total recognised gains and losses and cash flows for the financial year.

In preparing the Accounts, the Accounting Officer is required to comply with the requirements of the NHS Foundation Trust Financial Reporting Manual and in particular to:

— observe the Accounts Direction issued by Monitor, including the relevant accounting and disclosure requirements, and apply suitable accounting policies on a consistent basis
— make judgements and estimates on a reasonable basis
— state whether applicable accounting standards as set out in the NHS Foundation Trust Financial Reporting Manual have been followed, and disclose and explain any material departures in the financial statements
— prepare the financial statements on a going concern basis.

The Accounting Officer is responsible for keeping proper accounting records which disclose with reasonable accuracy at any time the financial position of the NHS foundation trust and to enable him/her to ensure that the accounts comply with requirements outlined in the above mentioned Act. The Accounting Officer is also responsible for safeguarding the assets of the NHS foundation trust and hence for taking reasonable steps for the prevention and detection of fraud and other irregularities.

To the best of my knowledge and belief, I have properly discharged the responsibilities set out in Monitor’s NHS Foundation Trust Accounting Officer Memorandum.

Signed

5 June 2009

Stuart Bell, C.B.E
Chief Executive
South London and Maudsley
NHS Foundation Trust
Statement on internal control —

1. Scope of responsibility
As Accounting Officer, I have responsibility for maintaining a sound system of internal control that supports the achievement of the NHS foundation trust’s policies, aims and objectives, whilst safeguarding the public funds and departmental assets for which I am personally responsible, in accordance with the responsibilities assigned to me. I am also responsible for ensuring that the NHS foundation trust is administered prudently and economically and that resources are applied efficiently and effectively. I also acknowledge my responsibilities as set out in the NHS Foundation Trust Accounting Officer Memorandum.

2. The purpose of the system of internal control
The system of internal control is designed to manage risk to a reasonable level rather than to eliminate all risk of failure to achieve policies, aims and objectives; it can therefore only provide reasonable and not absolute assurance of effectiveness. The system of internal control is based on an ongoing process designed to identify and prioritise the risks to the achievement of the policies, aims and objectives of the South London and Maudsley NHS Foundation Trust, to evaluate the likelihood of those risks being realised and the impact should they be realised, and to manage them efficiently, effectively and economically. The system of internal control has been in place in the South London and Maudsley NHS Foundation Trust for the year ended 31 March 2009 and up to the date of approval of the annual report and accounts.

As an employer with staff entitled to membership of the NHS Pension Scheme control measures are in place to ensure all employer obligations contained within the Scheme regulations are complied with. This includes ensuring that deductions from salary, employer’s contributions and payments into the Scheme are in accordance with the Scheme rules, and that member Pension Scheme records are accurately updated in accordance with the time scales detailed in the Regulations.

3. Capacity to handle risk
3.1 Overall responsibility for the management of risk lies with the Chief Executive as Accountable Officer, and the Executive Directors are collectively responsible for the appropriate operation of the Trust’s system of internal control and management. This responsibility is monitored through the following Sub-Committees of the Board of Directors, which are chaired by Non Executive Directors:

— Patient Safety and Service Improvement Committee
— Audit Committee.
— Activity and Finance Committee

These committees are required to ensure that the systems necessary to quality assure clinical care and organisational effectiveness at the
Trust are in place, and that the Trust is developing and delivering its stated goals and agreed action plans. Specific responsibilities are outlined in the Trust’s Risk Management Strategy (reviewed in Quarter 3 2008 and ratified by the Board of Directors in November 2008) as follows:

The Director of Finance and Corporate Governance has responsibility for managing the development and implementation of the Trust’s Integrated Governance framework as well as for non-clinical and financial risk management arrangements. This includes the ongoing development and maintenance of the Assurance Framework, Claims Management and Health and Safety;

The Director of Nursing and Education has joint delegated responsibility for clinical risk management, which includes clinical governance, medical devices, safeguarding children, serious incidents and complaints, and has overall responsibility for Education and Training and the Trust’s internal processes for the Standards for Better Health (SfBH) and NHS Litigation Authority (NHSLA) arrangements.

The Medical Director has joint delegated responsibility for clinical risk management, which includes clinical governance, medical devices, serious untoward incidents (SUIs) and complaints. The Medical Director is the nominated Trust Director for Infection Prevention and Control (DIPC).

The Director of Human Resources and Organisational Development has overall responsibility for the continuing suitability of the Trust’s staff, ensuring that adequate checks are carried out before they are employed.

The Director of Research and Development has overall responsibility for the Trust’s research portfolio, which includes ensuring that all research is ethically and scientifically sound and is conducted according to the Department of Health’s Research Governance Framework.

The Caldicott Guardian and the ICT Standards Manager review all data security Serious Untoward Incidents (SUIs).

Service and Clinical Directors have responsibility for operational risk management at Directorate level; and Risk management is a core component of the job descriptions of all senior management.

3.2 All Trust staff receive basic training on Health and Safety, Incident Reporting and Risk Management as part of the Trust’s Induction Programme. The Trust’s Risk Management and Assurance Strategy sets out further risk management training provided to staff to ensure that they are equipped to manage risks appropriate to their authority and duties. Risk management training needs and attendance at training sessions are followed up as part of the Performance Management process to ensure that all staff complete training which is essential to do their job competently and safely.

3.3 The Trust seeks to learn from good practice through a range of mechanisms including benchmarking, clinical supervision and reflective practice, individual and peer reviews, performance management, continuing professional development programmes, clinical audit, the application of evidence-based practice and reviewing...
Statement on internal control —

compliance with risk management standards. There are formal mechanisms in place to ensure that external changes to best practice, such as those issued by the National Institute for Health and Clinical Excellence, are incorporated into Trust policies and procedures.

4. The risk and control framework
4.1 The Risk Management and Assurance Strategy sets out an effective risk management system and supporting risk management procedures including:

— a risk analysis tool, developed in accordance with national guidance, that ensures a consistent approach is taken to prioritising risks and their treatment
— the development and maintenance of risk registers at directorate and departmental level, which are monitored via the Performance Management process and which inform the Trust-wide Corporate Risk Log and the Assurance Framework
— the responsibilities of all staff for managing risks within the scope of their role and responsibilities as employees of the Trust and as professionals working to professional codes of conduct
— the promotion of open and honest reporting of incidents, risks and hazards, supported by a range of policies with which staff are required to comply
— the escalation of issues and management action: risks that cannot be effectively controlled at a local level are escalated to a Senior Management or Executive Team
— a statement on responsible risk taking, which states that the Trust accepts that staff, users and carers will all make decisions that may not have predictable or definitely successful outcomes. The Trust supports staff in taking these decisions provided that they are made responsibly by reference to the principles of good professional policy, practice and protocol
— control measures are in place to ensure that all the organisation’s obligations under equality, diversity and human rights legislation are complied with.

Further developmental work continues to take place to improve and refine these systems and to ensure that the Trust learns from events to assure safe high quality care that is constantly improving.

4.2 Risk management continues to be embedded into the culture of the Trust through explicit processes for identifying, assessing and responding to potential opportunities and adverse effects, as follows:

All directorates have meetings to review directorate risk registers and identify and assess new operational risks. They also carry out detailed reviews, action planning and assurance checks in response to the Healthcare Commission’s Standards for Better Health.

Specific committees that consider potential risks faced by the Trust include:

— SUI monitoring committee
— Complaints monitoring committee
— Safeguarding children committee
— Safeguarding adults committee
Health, safety and fire committee
ICT security board
Caldicott committee
Mental Health Act committee
Infection control committee
Medical devices committee
Medicines management committee
Drugs and therapeutics committee
Clinical governance committees
Promoting safe and therapeutic services committee
Research and development committee.

The SUI and Complaints Monitoring Committees report directly to the Board of Directors; other committees escalate issues to the Risk Management Committee or Clinical Risk Committee as appropriate.

The Risk Management Committee considers Trust-wide operational risks escalated by directorates to determine whether these risks need to be placed on the Corporate Risk Log. Risk action plans are developed and monitored as required and the committee monitors the consistency and quality of directorate risk registers.

The Clinical Risk Committee considers Trust-wide clinical risks.

The Patient Safety and Service Improvement sub-committee of the Board of Directors is responsible for the development, management, and implementation of the Risk Management and Assurance Strategy. It reviews the Assurance Framework and Corporate Risk Log, particularly the adequacy of action plans and the progress being made to implement them. It also considers escalation reports from the Risk Management and Clinical Risk committees.

The Governance Executive has overall responsibility for governance issues and is the designated Information Governance Steering Group as defined by the Information Governance Toolkit.

The Audit Committee monitors the Internal and External Audit work plans, using the Assurance Framework to determine the annual Internal Audit Plan and reviewing the output report of the Internal Audit Review of Governance, Risk Management and SFH arrangements. It may review a sample of Assurance Framework entries to check whether the entries are appropriate and factually accurate.

The Board of Directors receives exception reports from the Patient Safety and Service Improvement Committee and the Audit Committee and reviews the full Assurance Framework twice a year.

4.3 There are robust formal mechanisms for engaging with partner organisations, service users and the wider public. Public stakeholders are involved in the risk management process in a variety of ways:

— The Trust is a member of the Lambeth Health and Social Care Partnership Board, the Southwark Partnership Board, the Healthy Croydon Partnership Board, the Lewisham Adult Strategic Partnership Board and Mental Health Partnership Board and the Lambeth and Southwark Chief Executives’ Group
— The Trust is an active member of King’s Health Partners Academic Health Sciences Centre
— The Trust works closely with the four NHS acute care providers in its local catchment area: Guy’s and St Thomas’ NHS Foundation Trust; King’s College Hospital NHS Foundation Trust; University Hospital Lewisham NHS Trust; and Mayday Healthcare NHS Trust. This includes Chief Executive-level strategic liaison groups, as well as working together on operational issues
— The Trust has a long standing, closely integrated partnership with the Institute of Psychiatry, King’s College London; and more broadly, the Trust has a wide range of contractual and non contractual partnerships with service user and carer groups, voluntary and community sector organisations and other statutory sector providers. Membership of the Members’ Council includes patients, public and staff as well as representatives of all key partners.

4.4 The ICT Security Board is responsible for organisational protection from ICT security threats and delivers improved Information and ICT Security through the review of incidents, policy development, education of users, highlighting risks and development of risk treatment plans.
Statement on internal control —

5. Review of economy, efficiency and effectiveness of the use of resources

5.1 The key processes to ensure that resources are used economically, efficiently and effectively include:

— the Performance Monitoring Tool, which has been developed to monitor the Foundation Trust compliance framework and governance guidance, local (internal and external) and national targets and the SfBH; the tool is used at monthly Performance Management reviews to give assurance of meeting, and prospective warning of not meeting, those targets in sufficient time to take corrective action
— the production of a monthly finance report to the Board, highlighting key variances from the agreed Plan
— the production of a summary financial report to each Trust Directorate and individual budget reports to each budget holder
— the production of annual reference costs to allow cost comparison with other Trusts;
— the production of a quarterly monitoring report to Monitor
— the Annual Planning Development Group, which oversees the submission of the Annual Plan to Monitor and reports to the Activity and Finance Sub-Committee, which oversees the Compliance Framework work streams on behalf of the Board
— The adherence to key Trust policies, such as Standing Financial Instructions and Standing Orders and the Treasury Management Policy.

5.2 The Internal Audit plan for 2008/09 was aligned to the Trust's Terms of Authorisation.

5.3 The Board reviews individual aspects of performance such as the business plan and supply strategy and gains overall assurance from key performance indicator (KPI) reports, the monitoring of cost improvement programme (CIP) targets and the Assurance Framework.

6. Review of effectiveness

6.1 As Accounting Officer, I have responsibility for reviewing the effectiveness of the system of internal control. My review of the effectiveness of the system of internal control is informed by the work of the internal auditors and the executive managers within the NHS foundation trust who have responsibility for the development and maintenance of the internal control framework, and comments made by the external auditors in their management letter and other reports. I have been advised on the implications of the result of my review of the effectiveness of the system of internal control by the Board, the Audit Committee and the Patient Safety and Service Improvement Committee and a plan to address weaknesses and ensure continuous improvement of the system is in place.

6.2 The Board of Directors has monitored delivery of the 2008/09 business plan throughout the year. The Governance Executive and the Patient Safety and Service Improvement Committee provide the Board of Directors with reports on risk
The Assurance Framework provides the Trust with evidence that the effectiveness of controls to manage the risks to the Trust achieving its principal objectives have been reviewed. The Board of Directors has approved the Assurance Framework, confirming that the risk control measures in place are reasonable and that action plans have been developed to improve upon the controls and the assurance processes where appropriate. The Assurance Framework has been reviewed regularly by the Board of Directors, the Governance Executive and the Patient Safety and Service Improvement Committee.

The Trust has reviewed the systems and procedures for securing personal data, including patient data in transit, and confirms that it is satisfied that these have been and remain compliant with relevant information governance guidance and the Data Protection Act 1998. There have been no significant data security Serious Untoward Incidents in the past year.

The Trust declared an overall score of 89% against the Information Governance Toolkit self assessment for 2008/09.

The Audit Committee has provided the Board of Directors with an independent and objective review of financial and corporate governance, and internal financial control within the Trust. The Audit Committee has received reports and/or assurances from external and internal audit and management. Internal Audit has reviewed and reported on control, governance and risk management processes, based on an audit plan approved by the Audit Committee. Internal Audit's work included identifying and evaluating controls and testing their effectiveness, in accordance with NHS Internal Audit Standards. Where scope for improvement was found, recommendations were made and appropriate action plans agreed with management. The Audit Committee has a mechanism to track management's progress implementing agreed recommendations.

The Trust achieved level 2 against the NHS Litigation Authority's Risk Management Standards for Mental Health & Learning Disability Trusts, with a score of 100%, in November 2008.

The Trust declared compliance with all core Standards for Better Health (SfBH) in its submission to the Healthcare Commission for 2008/2009.

The Trust has continued to monitor compliance with Patient Environment Action Team (PEAT) standards throughout 2008/2009, by internal and external assessments and ongoing maintenance programmes. The results of these assessments have been submitted to the National Patient Safety Authority (NPSA) and the Trust attained an average score of 4 (good) in all elements.

Conclusion
No significant internal control issues have been identified.

Signed
Chief Executive
5 June 2009
Independent Auditor’s report —

to the Members’ Council of South London and Maudsley NHS Foundation Trust

Opinion on the summary financial statements
I have examined the summary financial statement which comprises the Income and Expenditure Account, the Statement of Total Recognised Gains and Losses, the Balance Sheet and the Cash Flow Statement set out on pages 92 – 97.

This report is made solely to the Members’ Council of South London and Maudsley NHS Foundation Trust as a body in accordance with paragraph 24(5) of Schedule 7 of the National Health Service Act 2006. My work was undertaken so that I might state to the Members’ Council those matters I am required to state to it in an auditor’s report and for no other purpose. In those circumstances, to the fullest extent permitted by law, I do not accept or assume responsibility to anyone other than the Foundation Trust as a body, for my audit work, for the audit report or for the opinions I form.

Respective responsibilities of directors and auditor
The directors are responsible for preparing the Annual Report. My responsibility is to report to you my opinion on the consistency of the summary financial statement within the Annual Report with the statutory financial statements.

I also read the other information contained in the Annual Report and consider the implications for my report if I become aware of any misstatements or material inconsistencies with the summary financial statement.

Basis of opinion
I conducted my work in accordance with Bulletin 1999/6 ‘The auditors’ statement on the summary financial statement’ issued by the Auditing Practices Board. My report on the statutory financial statements describes the basis of my audit opinion on those financial statements.

Opinion
In my opinion the summary financial statement is consistent with the statutory financial statements of the foundation trust for the year ended 31 March 2009.

Jon Hayes
Officer of the Audit Commission
First Floor Millbank Tower
Millbank
London
SW1P 4HQ
Date 5 June 2009
The summary financial statements which have been approved by the Board, do not contain sufficient information to allow as full an understanding of the results and affairs of the Trust as would be provided by the full accounts. To obtain a full set of accounts please contact:

**Mark Nelson**  
South London and Maudsley NHS Foundation Trust  
Finance Department,  
Bethlem Royal Hospital,  
Monks Orchard Road,  
Beckenham, BR3 3BX  
E mark.nelson@slam.nhs.uk  
T 020 3228 4718

### Income and Expenditure

<table>
<thead>
<tr>
<th>Description</th>
<th>2009 £000’s</th>
<th>2008 £000’s</th>
</tr>
</thead>
<tbody>
<tr>
<td>— Income from continuing operations</td>
<td></td>
<td></td>
</tr>
<tr>
<td>From healthcare activities</td>
<td>311,337</td>
<td>284,166</td>
</tr>
<tr>
<td>Other operating income</td>
<td>43,269</td>
<td>52,955</td>
</tr>
<tr>
<td>— Expenditure on continuing operations</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Operating expenses</td>
<td>(353,309)</td>
<td>(325,361)</td>
</tr>
<tr>
<td>— Operating surplus from continuing operations</td>
<td>1,297</td>
<td>11,760</td>
</tr>
<tr>
<td>Profit on disposal of fixed assets</td>
<td>130</td>
<td>205</td>
</tr>
<tr>
<td>— Surplus before interest and taxation</td>
<td>1,427</td>
<td>11,965</td>
</tr>
<tr>
<td>Finance costs</td>
<td>(97)</td>
<td>(86)</td>
</tr>
<tr>
<td>Finance income</td>
<td>2,045</td>
<td>2,710</td>
</tr>
<tr>
<td>— Surplus before taxation</td>
<td>3,375</td>
<td>14,589</td>
</tr>
<tr>
<td>Taxation</td>
<td></td>
<td></td>
</tr>
<tr>
<td>— Surplus for the financial year after taxation</td>
<td>3,375</td>
<td>14,589</td>
</tr>
<tr>
<td>Dividends payable to the Government</td>
<td>(10,044)</td>
<td>(9,428)</td>
</tr>
<tr>
<td>— Retained surplus (deficit) for the financial year</td>
<td>(6,669)</td>
<td>5,161</td>
</tr>
</tbody>
</table>
Statement of total recognised gains and losses
Reconciliation of movements in Government funds

<table>
<thead>
<tr>
<th></th>
<th>2009 £000's</th>
<th>2008 £000's</th>
</tr>
</thead>
<tbody>
<tr>
<td>Surplus for the financial year</td>
<td>3,375</td>
<td>14,589</td>
</tr>
<tr>
<td>Fixed asset impairment losses offset against past revaluation and indexation</td>
<td>-</td>
<td>(2,209)</td>
</tr>
<tr>
<td>Unrealised surplus (deficit) on the revaluation of fixed assets and investments</td>
<td>(38,899)</td>
<td>26,695</td>
</tr>
<tr>
<td>Decrease due to the revaluation of donated assets</td>
<td>(1,136)</td>
<td>(197)</td>
</tr>
<tr>
<td>Decrease due to the depreciation of donated assets</td>
<td>(775)</td>
<td>(856)</td>
</tr>
<tr>
<td><strong>Total gains and losses recognised in the year</strong></td>
<td><strong>(37,435)</strong>*</td>
<td>38,022</td>
</tr>
</tbody>
</table>

The accompanying notes and statement of accounting policies form part of this statement.

---

Reconciliation of movements in Government funds

<table>
<thead>
<tr>
<th></th>
<th>£000's</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total gains and losses recognised for the year</td>
<td>(37,435)</td>
</tr>
<tr>
<td>Decrease in donated asset reserve</td>
<td>1,911</td>
</tr>
<tr>
<td>Dividends payable to Government</td>
<td>(10,044)</td>
</tr>
<tr>
<td>New Public Dividend Capital received</td>
<td>-</td>
</tr>
<tr>
<td>Public Dividend Capital repaid</td>
<td>-</td>
</tr>
<tr>
<td><strong>Net increase (decrease) in Government funds</strong></td>
<td><strong>(45,568)</strong>*</td>
</tr>
</tbody>
</table>

---

Government funds at beginning of the year | 342,213 |

---

Government funds at end of the year | 296,645 |

---

Donated asset reserve | 315,068 |
## Summary Accounts —

### Balance Sheet

<table>
<thead>
<tr>
<th></th>
<th>31 Mar 2009 £000's</th>
<th>31 Mar 2008 £000's</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Fixed Assets</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Intangible assets</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Tangible assets</td>
<td>302,331</td>
<td>345,595</td>
</tr>
<tr>
<td>Investments</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td><strong>Total Fixed Assets</strong></td>
<td>302,331</td>
<td>345,595</td>
</tr>
<tr>
<td><strong>Current Assets</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Stocks and work in progress</td>
<td>326</td>
<td>287</td>
</tr>
<tr>
<td>Debtors - due after one year</td>
<td>1,098</td>
<td>1,097</td>
</tr>
<tr>
<td>Debtors - due within one year</td>
<td>11,231</td>
<td>12,234</td>
</tr>
<tr>
<td>Short-term investments</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Cash at bank and in hand</td>
<td>52,070</td>
<td>52,873</td>
</tr>
<tr>
<td><strong>Total Current Assets</strong></td>
<td>64,725</td>
<td>66,491</td>
</tr>
<tr>
<td><strong>Current Liabilities</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Creditors : amounts falling due within one year</td>
<td>(45,973)</td>
<td>(43,222)</td>
</tr>
<tr>
<td><strong>Net Current Liabilities</strong></td>
<td>18,752</td>
<td>23,269</td>
</tr>
<tr>
<td><strong>Total Assets less Current Liabilities</strong></td>
<td>321,083</td>
<td>368,864</td>
</tr>
<tr>
<td><strong>Non-Current Liabilities</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Creditors : amounts falling due after more than one year</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Provisions for liabilities and charges</td>
<td>(6,015)</td>
<td>(6,317)</td>
</tr>
<tr>
<td><strong>Total Non-Current Liabilities</strong></td>
<td>(6,015)</td>
<td>(6,317)</td>
</tr>
<tr>
<td><strong>Total assets employed</strong></td>
<td>315,068</td>
<td>362,547</td>
</tr>
<tr>
<td><strong>Capital and Reserves (Taxpayers Equity)</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Public dividend capital</td>
<td>179,280</td>
<td>179,280</td>
</tr>
<tr>
<td>Revaluation reserve</td>
<td>123,155</td>
<td>163,050</td>
</tr>
<tr>
<td>Donated asset reserve</td>
<td>18,423</td>
<td>20,334</td>
</tr>
<tr>
<td>Income and expenditure reserve</td>
<td>(5,790)</td>
<td>(117)</td>
</tr>
<tr>
<td><strong>Total Taxpayers Equity</strong></td>
<td>315,068</td>
<td>362,547</td>
</tr>
<tr>
<td>Account</td>
<td>2009 £000's</td>
<td>2008 £000's</td>
</tr>
<tr>
<td>--------------------------------------------------</td>
<td>-------------</td>
<td>-------------</td>
</tr>
<tr>
<td><strong>Net cash inflow from operating activities</strong></td>
<td>22,055</td>
<td>30,653</td>
</tr>
<tr>
<td><strong>Returns on investments and servicing of finance</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Interest received</td>
<td>2,077</td>
<td>2,704</td>
</tr>
<tr>
<td>Interest paid</td>
<td>(9)</td>
<td>-</td>
</tr>
<tr>
<td><strong>Net cash inflow from returns on investments and servicing of finance</strong></td>
<td>2,068</td>
<td>2,704</td>
</tr>
<tr>
<td><strong>Capital expenditure</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Purchases of tangible fixed assets</td>
<td>(16,659)</td>
<td>(21,751)</td>
</tr>
<tr>
<td>Disposals of tangible fixed assets</td>
<td>1,777</td>
<td>1,908</td>
</tr>
<tr>
<td><strong>Net cash (outflow) from capital expenditure</strong></td>
<td>(14,882)</td>
<td>(19,843)</td>
</tr>
<tr>
<td><strong>Dividend paid</strong></td>
<td>(10,044)</td>
<td>(9,428)</td>
</tr>
<tr>
<td><strong>Net cash inflow (outflow) before use of liquid resources and financing</strong></td>
<td>(803)</td>
<td>4,086</td>
</tr>
<tr>
<td><strong>Financing</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Public Dividend Capital received</td>
<td>-</td>
<td>14,129</td>
</tr>
<tr>
<td>Public Dividend Capital repaid</td>
<td>-</td>
<td>(1,930)</td>
</tr>
<tr>
<td>Capital received from other grants</td>
<td>-</td>
<td>40</td>
</tr>
<tr>
<td><strong>Net cash inflow from financing</strong></td>
<td>-</td>
<td>12,239</td>
</tr>
<tr>
<td><strong>Increase (decrease) in cash during the year</strong></td>
<td>(803)</td>
<td>16,325</td>
</tr>
</tbody>
</table>
## Summary Accounts

### Salary and pension entitlements of senior employees

<table>
<thead>
<tr>
<th>Name</th>
<th>Position</th>
<th>From/Until</th>
<th>Salary</th>
<th>A</th>
<th>B</th>
<th>C</th>
<th>D</th>
<th>E</th>
<th>F</th>
<th>G</th>
</tr>
</thead>
<tbody>
<tr>
<td>Madeliene Long</td>
<td>Chair</td>
<td>2009</td>
<td>55-60</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td></td>
<td></td>
<td>2008</td>
<td>55-60</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Michael Barrett</td>
<td>Non-Executive Director</td>
<td>2008 until 30th June 2007</td>
<td>&lt;5</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Chris Clare</td>
<td>Non Executive Director</td>
<td>from 7th January 2009</td>
<td>2009</td>
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<td>2009</td>
<td>15-20</td>
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<td></td>
<td>and Chair of the Audit Committee</td>
<td>from 1st May 2007 and</td>
<td>2008</td>
<td>10-15</td>
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<td>Sue Harvey</td>
<td>Non Executive Director</td>
<td>2008 until 31st August 2007</td>
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<td>Kumar Jacob</td>
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<td>2009</td>
<td>10-15</td>
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<td>until 7th June 2007</td>
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<td>Eric Taylor</td>
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<td>from 1st July 2007</td>
<td>2009</td>
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</tbody>
</table>
### Key

- **A** – Other remuneration
- **B** – Real increase in pension at age 60
- **C** – Lump sum at age 60 related to real increase in pension
- **D** – Total accrued pension at age 60
- **E** – Lump sum at age 60 related to accrued pension
- **F** – Cash equivalent transfer value
- **G** – Real increase in cash equivalent transfer value

Names highlighted in bold are current Board members, Board members in 2007/08 are also included.

* Eric Taylor declined remuneration of £5 – 10k for the period to 31st March 2008.  
** Stuart Bell transferred an existing pension fund into the NHS Pension Fund during 2008/09.

<table>
<thead>
<tr>
<th>Name</th>
<th>Position</th>
<th>Salary</th>
<th>A</th>
<th>B</th>
<th>C</th>
<th>D</th>
<th>E</th>
<th>F</th>
<th>G</th>
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<td>Gus Heafield</td>
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<td>12</td>
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<td>41</td>
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<td>2008 90-95</td>
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<td>255</td>
<td>n/a</td>
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<td>David Roy</td>
<td>Medical Director until 31st July 2007</td>
<td>2008 20-24</td>
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There were no golden hello payments or payments made for compensation for losses of office to senior employees, nor did senior employees receive benefits-in-kind.

A Cash Equivalent Transfer Value (CETV is the actuarially assessed capital value of the pension scheme benefits accrued by a member at a particular point in time. The benefits valued are the member's accrued benefits and any contingent spouse's pension payable from the scheme. A CETV is a payment made by a pension scheme, or arrangement to secure pension benefits in another pension scheme or arrangement when the member leaves a scheme and chooses to transfer the benefits accrued in their former scheme. The pension figures shown relate to the benefits that the individual has accrued as a consequence of their total membership of the pension scheme, not just their service in a senior capacity to which the disclosure applies. The CETV figures include the value of any pension benefits in another scheme or arrangement which the individual has transferred to the NHS pension scheme. They also include any additional pension benefit accrued to the member as a result of their purchasing additional years of pension service in the scheme at their own cost. CETVs are calculated within the guidelines and framework prescribed by the Institute and Faculty of Actuaries.

Real Increase in CETV – This reflects the increase in CETV effectively funded by the employer. It takes account of the increase in accrued pension due to inflation, contributions paid by the employee (including the value of any benefits transferred from another pension scheme or arrangement) and uses common market valuation factors for the start and end of the period.
Credits —

Produced by:
— Communications Department

Contributors:
— Phil Durrant (photography)
  www.philipdurrant.co.uk
— Ian M McMillan
— Alex Wafer

Design:
— Raw Nerve
  www.raw-nerve.co.uk
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