

**A MEETING OF THE COUNCIL OF GOVERNORS OF  
THE SOUTH LONDON AND MAUDSLEY NHS FOUNDATION TRUST  
WILL BE HELD ON THURSDAY, 16 SEPTEMBER 2014 AT 3:30 PM  
IN THE CONNECT ROOM, LOWER GROUND FLOOR, MAUDSLEY LEARNING CENTRE**

**AGENDA**

- 1 Welcomes, introductions and apologies for absence.
- 2 To receive any declarations of interest.
- 3 Questions and answers (10 minutes – see overleaf).

**FOR DECISION**

- 4 To agree the minutes of the Council of Governors meeting held on Thursday, 12 June 2014 and to note any matters arising. Attachment A
- 5 To receive an update from the Nominations Committee. To be tabled
- 6 FT Constitution Attachment B

**FOR DISCUSSION**

- 7 Workforce strategy. Presentation
- 8 Report from the external auditor Attachment C
- 9 To receive reports from the Council of Governors' Working Groups: Attachment D
  - Quality (Dr Tom Werner)
  - Annual Plan development (Angela Flood)
  - Bids Steering Group (Roger Oliver)
  - Membership Development and Communications (Dr Dele Olajide)

**FOR INFORMATION**

- 10 King's Health Partners update. Verbal
- 11 Chair's report and visits. Verbal
- 12 Chief Executive's and Directors' reports (including Monitor review update). Attachment E
- 13 Forward planner.
- 14 Any other urgent business.
- 15 To note the date of the next meeting of the Council of Governors – 11<sup>th</sup> December 2014 at 5.00 pm

Please send apologies to Carol Stevenson telephone 020 3228 2441 or email [membership@slam.nhs.uk](mailto:membership@slam.nhs.uk)

### Item 3 - questions and answers

At the joint meeting between the Council of Governors and Board of Directors held in November 2011 it was agreed that a 10 minute slot would be made available for members of the Trust to submit questions related to services provided by the Trust. In order that a considered response can be made at the meeting, members are asked to submit any questions to the Paul Mitchell, Trust Secretary by 10.00 am on Monday, 15 September 2014.

These can be made by:

**Post:** Trust HQ, Maudsley hospital, Denmark Hill, SE5 8AZ

**Telephone:** 020 3228 5376

**Email:** paul.mitchell@slam.nhs.uk

**Attachment A**

**COUNCIL OF GOVERNORS – SUMMARY REPORT**

<b>Date of meeting:</b>	16 September 2014
<b>Name of Report:</b>	Minutes of the meeting held on 12 June 2014
<b>Author:</b>	Paul Mitchell, Trust Secretary
<b>Presented by:</b>	Madeliene Long, Chair

**Purpose of the report:**

To agree the minutes and to note any matters arising.

**MINUTES OF THE MEETING OF THE COUNCIL OF GOVERNORS OF  
 THE SOUTH LONDON AND MAUDSLEY NHS FOUNDATION TRUST (SLaM)  
 HELD ON THURSDAY 12<sup>th</sup> JUNE 2014  
 AT THE ORTUS LEARNING CENTRE**

<b>PRESENT</b>	Madeliene Long	Chair
<b>Elected Governors</b>	Chris Anderson	Service user governor
	Chris Collins	Service user governor
	Stephanie Correia	Public governor
	Alistair Edwards	Service user governor
	Angela Flood	Carer governor
	Mark Ganderton	Public governor
	Francis Keaney	Staff governor
	Matthew McKenzie	Carer governor
	Dr Dele Olajide	Staff governor
	Roger Oliver	Carer governor
	Iyoni Ranasinghe	Staff governor
	Noel Urwin	Public governor
	Dr Tom Werner	Staff governor
<b>Appointed Governors</b>	Dr Raj Mitra	Lambeth Clinical Commissioning Group (CCG)
	Tim Smart	King's College Hospital FT (KCH)
<b>In attendance</b>	Dr Martin Baggaley	Medical Director
	Dr Neil Brimblecombe	Director of Nursing
	Nick Dawe	Chief Operating Officer
	Gus Heafield	Chief Financial Officer
	Olivia Howarth	Business Manager to the CEO office
	Dr Matthew Patrick	Chief Executive Officer (CEO)
	Paul Mitchell	Trust Secretary
	Zoe Reed	Director of Development and Community (DOC)
	Carol Stevenson	Membership Officer
	Jeff Worley	Member
<b>Apologies</b>	Ian Creagh	King's College London (KCL)
	Andrew Glyn	Public governor
	John Muldoon	Public governor
	Girda Niles	Guys and St Thomas' Hospital FT (GSTT)
	Crada Onuegbu	Lambeth Council
	Paul Paterson	Service user governor
	Gabrielle Richards	Head of Occupational Therapy

Ref	Issue	Who
<b>MC/ 14/16</b>	<p><b>DECLARATIONS OF INTEREST</b></p> <p>It was noted that declarations of interest could be given at any time during the meeting. Tom Werner declared an interest as Director of Let's Be Well.</p>	
<b>MC/ 14/17</b>	<p><b>QUESTIONS AND ANSWERS</b></p> <p>There were no pre-notified questions.</p> <p>Jeff Worley, member of the Trust, asked for a list of the conditions that were set by Patricia Hewitt, Secretary of state for Health, at the time the Emergency Clinic closed. This will be produced by the time of the next meeting.</p>	PM
<b>MC/ 14/18</b>	<p><b>MINUTES OF THE MEETING OF 12<sup>TH</sup> MARCH 2014</b></p> <p>The minutes of the meeting of 12<sup>th</sup> March 2014 were <b>AGREED</b> to be a correct record.</p> <p><b>Matters arising:</b></p> <p>14/08 Two governors need to be appointed to Engaging Patients, Involving Carers (EPIC). This is subject to on-going dialogue with Zoe Reed. Consideration is being given to establishing a working group for involvement and social inclusion.</p>	PM
<b>MC/ 14/19</b>	<p><b>NOMINATIONS COMMITTEE</b></p> <p>It was noted that the Council of Governors unanimously agreed at a recent special meeting the appointment of two Non-Executive Directors (NEDs) who will take up their appointments in mid-June for three year terms.</p> <p>Lesley Calladine has been appointed as NED leading on Quality and Safety and Alan Downey will be the NED leading on Commercial Development.</p> <p>Lesley is Vice President, Health and Safety, BP Ltd. She has considerable experience in the area of risk, safety and compliance and a track record of leading and supporting change, driving up safety and quality standards for businesses.</p> <p>Alan is Chair of KPMG's Public Sector Practice. He brings a strong leadership track record and has advised major Whitehall departments on issues ranging from deficit reduction to reform of the criminal justice system.</p> <p>At the same time Kumar Jacob and Harriet Hall were stepping down after serving for a number of years as NEDs. Kumar will also step down as Chair of the Maudsley Charity. They were both thanked for the huge contribution they have</p>	

	<p>made to running of the organisation.</p> <p>Madeliene Long confirmed that steps were underway to recruit a further NED.</p>	
<p><b>MC/ 14/20</b></p>	<p><b>DEVELOPMENT OF THE TRUST'S FIVE YEAR STRATEGY</b></p> <p>Matthew Patrick introduced the Five year plan and highlighted the Trust's agreed purpose – "Everything we do is to improve the lives of the people and communities we serve and to promote mental health and wellbeing for all."</p> <p>He summarised the aims of the strategy:</p> <ul style="list-style-type: none"> <li>• Transform the nature and value of our local services through partnerships that deliver integrated care built around the needs of individuals and communities</li> <li>• Move from treatment to prevention, working to empower people to help them stay well through effective self-management and peer support</li> <li>• Build on our high quality specialist services for those with complex and intensive care needs through focus, scale and continuous quality innovation</li> <li>• Manage our costs effectively so we can re-invest in our people, innovation, research and training</li> <li>• Secure our long-term financial position through new growth at fair levels of profitability</li> </ul> <p>Gus Heafield presented the financial context of the plan:</p> <ul style="list-style-type: none"> <li>• Following a very challenging 13/14 we have secured investment from CCGs and have reviewed many of our systems and processes to focus on transformation and delivery to ensure we meet our targets to breakeven in 14/15 and 15/16</li> <li>• Our planning assumptions indicate that there are still very significant financial challenges going forward and that cost reductions and other gains of nearly £15m per annum will be required in the three years from 16/17-18/19</li> <li>• The objectives of our five year financial plan are to deliver financial stability, and ensure that there are sufficient funds available for investment in transformation of our services; clinical environments and in information technology to support our value added approach</li> <li>• Our financial plan requires us to maintain our critical mass to ensure we have the flexibility and scope to continue to develop and innovate</li> <li>• We will need to secure replacement and new income from inside and outside the NHS; identify innovative ways of delivering services more efficiently and effectively particularly through partnerships and collaboration; and continue our drive to secure savings and provide services that cover their costs</li> </ul> <p>Nick Dawe presented the economic model:</p> <ul style="list-style-type: none"> <li>• No adjustment to year 2 (15/16) of the Operational Plan (optional) because no material movements</li> <li>• Operational Plan assumes financial stability driven by breakeven and cash</li> </ul>	

	<p>surplus for maintenance expenditure</p> <ul style="list-style-type: none"> <li>• To do so requires us to maintain turnover at £350m minimum and £300m clinical income</li> <li>• CIPs requirement approx. £15m per annum 16/17-18/19</li> <li>• EBITDA increasing in current model to maintain breakeven to £20m (5.7% margin)</li> <li>• CoSRR (simple average rounded up) at 4 for each of five years driven by liquidity. Liquidity position 33 days based on high level of cash and no borrowings</li> <li>• We have scope to reduce CIPs, EBITDA and plan for a net deficit and retain a CoSRR at 3 although this would impact on cash reserves and funding available for investment.</li> <li>• Draft five-year financial model and key assumptions available as a separate sheet</li> </ul> <p><b>Points raised in discussion:</b></p> <ul style="list-style-type: none"> <li>• CCGs want to see the introduction of changes to service models as soon as possible, benefits will include a reduced pressure on the bed stock and cost reductions in the earlier years of the plan.</li> <li>• Positive feedback has been received from patients and GPs. Partners would like to be involved in research.</li> <li>• Sources of further income are being pursued. In practice the Trust needs to find £15 million/year to stand still. Options are to look for additional service opportunities; specialised services; different models of care e.g. digital; training opportunities.</li> <li>• Integrated care – detailed analysis of the cost to SLaM and the benefits to the wider community has been initiated.</li> <li>• Scope for SLaM being more involved in housing supply. Currently approximately 30% of bed occupancy is related to housing issues which are preventing discharge. There is scope for working with the voluntary sector and through CCGs. The Trust could use nomination rights for housing to assist the rehabilitation pathway.</li> <li>• Workforce issues were crucial to the success of any major change programme. The importance of staff having the skills to deliver new services was emphasised.</li> <li>• Use of carers and their scope for input to care programmes.</li> </ul>	
<p><b>MC/ 14/21</b></p>	<p><b>TRUST SECRETARY'S REPORT</b></p> <p>Paul Mitchell introduced his report.</p> <p>A few elected governors have not yet joined a working group. He will allocate individuals to a group if there is no response.</p> <p>Noel Urwin, the Lead governor, has confirmed that he will not be standing for re-election. Paul Mitchell will be asking for nominations so that an election process can be concluded before the next CoG meeting. These elections will be held annually in future years. Madeliene Long thanked Noel Urwin for his enormous contribution to the development of the Council of Governors since authorisation.</p> <p>Paul Mitchell confirmed that he would be developing proposals for changes to the</p>	<p>PM</p> <p>PM</p>

	FT Constitution for approval at the APM. He would arrange a meeting beforehand to ensure Governor involvement in the process.	PM
<b>MC/ 14/22</b>	<p><b>COUNCIL OF GOVERNORS' WORKING GROUPS</b></p> <p><b>Quality Group</b> Tom Werner reported that the majority of the targets set in the 2013/14 Quality Account had been achieved. The quality group had examined the 2014/15 Quality Account for 2014/15 and attached a statement.</p> <p><b>Planning and Strategy Group</b> Angela Flood reported that the group name had changed to the Planning and Strategy group. The terms of reference have been agreed. The group had commented during the on-going development of the two year operational and five year strategic plans.</p> <p><b>Bids Steering Group</b> Roger Oliver updated on Smile for Health. So far, 209 expressions of interest and 30 actual bids had been submitted. Outstanding reports and receipts from the Keep on Smiling scheme were being pursued. The proposal from Professor Diana Rose for evaluating Smile for Health had been turned down.</p> <p><b>Membership and Communications Group</b> Dele Olajide highlighted the Happy Heads festival which was taking place on 26<sup>th</sup> July. This was a special event to engage with young people on mental health issues.</p>	
<b>MC/ 14/23</b>	<p><b>KINGS HEALTH PARTNERS (KHP) UPDATE</b></p> <p>Madeliene Long reported that Simon Stevens (new CE of NHS England) will be attending and speaking at the KHP conference the following week.</p> <p>A joint KHP governors meeting was being arranged.</p>	
<b>MC/ 14/24</b>	<p><b>CHAIR'S VISITS</b></p> <p>Madeliene Long reported that she had attended the KHP Nursing conference and would be visiting AL3 ward next week.</p>	
<b>MC/ 14/25</b>	<p><b>CHIEF EXECUTIVE'S AND DIRECTORS' REPORTS</b></p> <p>Matthew Patrick referred to his report. He highlighted that the Maudsley Learning Centre had received a RIBA award and that SLaM's television documentary Bedlam had won a BAFTA award.</p>	

<b>MC/ 14/26</b>	<b>ANY OTHER BUSINESS</b> There was none.	
<b>MC/ 14/27</b>	<b>NEXT MEETING</b> Tuesday 16 <sup>th</sup> September 2014 at 3.30pm in the Maudsley Learning Centre, to be followed by the Annual Public Meeting.	

CMS / June 2014

**Attachment B**

**COUNCIL OF GOVERNORS – SUMMARY REPORT**

**Date of meeting:** 16 September 2014  
**Name of report:** Changes to the FT Constitution  
**Author:** Paul Mitchell, Trust Secretary  
**Presented by:** Madeliene Long, Chair

**Purpose of the report:**

To receive proposals for changes to the FT Constitution.

This paper has been circulated to the Council of Governors for comments. If agreed the following is recommended:

- 3.1 Take to the meeting of the Board of Directors in September 2014.
- 3.2 Delegate responsibility for drafting any agreed amendments to the Constitution to the Trust Secretary.

## **Review of FT Constitution**

### **1. Introduction**

The Foundation Trust's Constitution is the key document that regulates the membership, election of governors and the appointment of the Chair, Non-Executive Directors and the Chief Executive. The commencement orders relating to the Health and Social Care Act 2012 (H&SCA) passed responsibility for approving the Constitution to the Board of Directors and Council of Governors. Amendments required as a result of changes to the Monitor model Constitution have previously been approved by Monitor in 2012.

In the intervening time a number of proposals have been put forward for consideration. It is now timely carry out a wider review of the FT Constitution and make recommendations to meetings of the Board of Directors and Council of Governors.

### **2. Proposed changes to the current Constitution**

#### **2.1 Split of patient constituency**

Legal advice received confirms that if the patient constituency is split it must be split three ways ie carers, patient grouping 1, patient grouping 2. The current arrangement splits the constituency between three carers, six service users (local) and three service users (national). In practice it has proved to be difficult to recruit to service users (national) and in effect the CoG has been carrying three vacancies. Other options have been considered such as a split by age or diagnosis.

**It is proposed that the CoG retains the geographical split but moves to an 8:1 split of local to national from the current 6:3 split.**

#### **2.2 Size of the Council of Governors (Members' Council)**

There are currently 26 elected and 13 nominated governors plus the Chair which forms a governing body of 40. In addition there has to be a majority of patient and public governors (20) over staff and stakeholders (19). Any additional stakeholders would need to be balanced by an increase in patient/public governors. It is important to retain a body that is of a suitable size so as to be effective in making decisions.

Other organisations have requested a formal place on the CoG, specifically the London Borough of Bromley. There could be similar arguments for other SE London Boroughs such as Bexley or Greenwich or Kent where we provide CAMHS being offered a place on the CoG. Likewise other partner organisations such as the Metropolitan Police could be offered a place.

A priority for the CoG is to increase the number of young members, both young service users and affiliated student organisations.

**It is proposed that associate status is introduced to cover other local partner organisations and young people.**

### **2.3 Mental health charity**

The following National Charities are listed as eligible to take up a place on the CoG:

Depression Alliance  
Richmond Fellowship  
King's Fund  
Rethink  
Manic Depression Fellowship  
Sainsbury Centre for Mental Health  
Mencap  
SANE  
Mental Health Foundation  
Together  
MIND  
Turning Point  
Alzheimer's Society

Since FT authorisation MIND has taken up a position on the CoG.

**It is proposed that another charity is now offered a place on the CoG. The recommended charity is Mencap.**

### **2.4 Commercial activities and significant transactions**

The phraseology used to describe commercial activity is "non principal purpose activities" and these require governor approval for planned increases of more than 5%. Likewise, the H&SCA gives Trusts the option of defining significant transactions. The current definition set out by Monitor is that transactions representing in excess of 25% of gross assets require approval by governors. These definitions were agreed in principle by the Board and CoG in September 2013 subject to legal advice.

**It is proposed that the definitions relating to commercial activities and significant transactions should be reflected in the Constitution.**

### **3. Recommendation for action**

3.1 Take to the respective meetings of the Council of Governors (Members' Council) and Board of Directors in September 2014.

3.2 Delegate responsibility for drafting agreed amendments to the constitution to the Trust Secretary.

Paul Mitchell  
Trust Secretary  
August 2014

South London and Maudsley NHS Foundation Trust

Findings and Recommendations from the 2013/14 NHS  
Quality Report External Assurance Review

*Final Report for the Council of Governors*

the  
Distinctive  
audit

29 May 2014

Dear Governors

We have pleasure in setting out in this document our report to the Council of Governors of South London and Maudsley NHS Foundation Trust on our external assurance review of the 2013/14 Quality Report. This report covers the principal matters that have arisen from our review.

We look forward to discussing our findings with you at your Council of Governors meeting in September 2014.

Yours faithfully



Senior Statutory Auditor

# Contents

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We would like to take this opportunity to thank the management team for their assistance and co-operation during the course of our review



The big picture

# The big picture

We have completed our Quality Report testing and have issued our limited assurance opinion.

## Status of our work

- We have completed our work and are in a position to issue our final report to the Governors.
- The scope of our work is to support a “limited assurance” opinion, which is based upon procedures specified by Monitor in their “Detailed Guidance for External Assurance on Quality Reports 2013/14”.
- In response to the growth of performance indicators across the NHS, we have developed a framework of considerations for evaluating data quality. We have used this framework in evaluating our findings and the recommendations we have raised.
- The Trust no longer applies local exemptions to the Access to Crisis Resolution Team indicator, which was the basis for our modified opinion last year. Consequently, based on our work to date, we have signed an unmodified opinion for inclusion in your 2013/14 Annual Report.

## Context

Q3 Governance Risk Rating: **Green**

The Care Quality Commission inspected a number of locations during the year and found environmental issues, which will be addressed during 2014/15

	2013/14	2012/13
Length of Quality Report	44 pages	42 pages
Quality Priorities	9	11
Future year Quality Priorities	3	3

## Scope of work

We are required to:

- Review the content of the Quality Report for compliance with the requirements set out in Monitor’s Annual Reporting Manual (“ARM”).
- Review the content of the Quality Report for consistency with various information sources specified in Monitor’s detailed guidance, such as Board papers, the Trust’s complaints report, staff and patients surveys and Care Quality Commission reports.
- Perform sample testing of three indicators.
  - The Trust has selected Minimising Delayed Transfer of Care and Access to Crisis Resolution Teams as its publically reported indicators – the alternative was Care Programme Approach 7 day follow-up. We also tested these indicators last year.
  - For 2013/14, all Trusts are required to have testing performed on a local indicator selected by the Council of Governors. The Trust has selected ‘the number of complaints in the category of staff attitude and behaviour as a proportion of the total complaints received’.
  - The scope of testing includes an evaluation of the key processes and controls for managing and reporting the indicators; and sample testing of the data used to calculate the indicator back to supporting documentation.
- Provide a signed limited assurance report, covering whether:
  - Anything has come to our attention that leads us to believe that the Quality Report has not been prepared in line with the requirements set out in the ARM; or is not consistent with the specified information sources; or
  - There is evidence to suggest that the Minimising Delayed Transfer of Care and Access to Crisis Resolution Home Treatment Teams indicators have not been reasonably stated in all material respects in accordance with the ARM requirements.
  - Provide this report to the Council of Governors, setting out our findings and recommendations for improvements for the indicators tested: Minimising Delayed Transfer of Care; Access to Crisis Resolution Teams and the number of complaints in the category of staff attitude and behaviour as a proportion of the total complaints received.

# The big picture (continued)

We have not identified any significant issues from our work.

## Content and consistency review



We have completed our content and consistency review and nothing has come to our attention that causes us to believe that, for the year ended 31 March 2014 the Quality Report is not prepared in all material respects in line with the criteria set out in the ARM.

		Overall conclusion
<b>Content</b>		
Are the Quality Report contents in line with the requirements of the Annual Reporting Manual?		<b>G</b>
<b>Consistency</b>		
Are the contents of the Quality Report consistent with the other information sources we have reviewed (such as Internal Audit Reports and reports of regulators)?		<b>G</b>

## Performance indicator testing



Monitor requires Auditors to undertake detailed data testing on a sample basis of two mandated indicators. We perform our testing against the six dimensions of data quality that Monitor specifies in its guidance.

From our work, nothing has come to our attention that causes us to believe that, for the year ended 31 March 2014, the indicators in the Quality Report subject to limited assurance have not been reasonably stated in all material respects in accordance with the ARM and the six dimensions of data quality set out in the "Detailed Guidance for External Assurance on Quality Reports 2013/14".

	Delayed Transfer of Care	Access to Crisis Resolution Team	Staff attitude complaints
<b>Accuracy</b>			
Is data recorded correctly and is it in line with the methodology.	<b>B</b>	<b>B</b>	<b>G</b>
<b>Validity</b>			
Has the data been produced in compliance with relevant requirements.	<b>G</b>	<b>B</b>	<b>G</b>
<b>Reliability</b>			
Has data been collected using a stable process in a consistent manner over a period of time.	<b>G</b>	<b>G</b>	<b>G</b>
<b>Timeliness</b>			
Is data captured as close to the associated event as possible and available for use within a reasonable time period.	<b>G</b>	<b>G</b>	<b>B</b>
<b>Relevance</b>			
Does all data used generate the indicator meet eligibility requirements as defined by guidance.	<b>G</b>	<b>G</b>	<b>G</b>
<b>Completeness</b>			
Is all relevant information, as specific in the methodology, included in the calculation.	<b>G</b>	<b>B</b>	<b>B</b>
<b>Recommendations identified?</b>	x	✓	✓
<b>Overall Conclusion</b>	<b>B</b>	<b>B</b>	<b>B</b>
	Unmodified Opinion	Unmodified Opinion	No opinion required
<b>G</b>	No issues noted	<b>B</b>	Satisfactory – minor issues only
<b>A</b>	Requires improvement	<b>R</b>	Significant improvement required

# Content and consistency findings

# Content and consistency review findings

## The readability of the Quality Report could be improved

The Quality Report is intended to be a key part of how the Trust communicates with its stakeholders.

Our work is based around reviewing content against specified criteria and considering consistency against other documentation. Although outside the formal scope of our work, we have also made recommendations to management to assist in preparing a high quality document. We have summarised below our overall assessment of the Quality Report, based upon the points identified in our NHS Briefing on Quality Accounts from our wide experience.

Key questions	Assessment	Statistics
<ul style="list-style-type: none"> <li>Is the length and balance of the content of the report appropriate?</li> </ul>	G	Length: 44 pages
<ul style="list-style-type: none"> <li>Is there an introduction to the Quality Report that provides context?</li> </ul>	G	
<ul style="list-style-type: none"> <li>Is there a glossary to the Quality Report?</li> </ul>	A	Patient Safety: 3 Clinical Effectiveness: 3 P. Experience: 3
<ul style="list-style-type: none"> <li>Is the number of priorities appropriate across all three domains of quality (Patient Safety, Clinical Effectiveness and Patient Experience)?</li> </ul>	G	
<ul style="list-style-type: none"> <li>Has the Trust set itself SMART objectives which can be clearly assessed?</li> </ul>	G	Flesch reading score: 39.1
<ul style="list-style-type: none"> <li>Does the Quality Report clearly present whether there has been improvement on selected priorities?</li> </ul>	G	
<ul style="list-style-type: none"> <li>Is there appropriate use of graphics to clarify messages?</li> </ul>	G	
<ul style="list-style-type: none"> <li>Does there appear to have been appropriate engagement with stakeholders (in both choosing priorities as well as getting feedback on the draft Quality Report)?</li> </ul>	G	
<ul style="list-style-type: none"> <li>Is the language used in the Quality Report at an appropriate readability level?</li> </ul>	A	

G No issues noted    
 B Satisfactory – minor issues only    
 A Requires improvement    
 R Significant improvement required

### Deloitte view

Overall, the Quality Report provides a concise summary of performance over 2013/14.

The Trust has been able to demonstrate that it has engaged with stakeholders to identify priorities for 2014/15, which are clearly aligned to the three domains of quality, and also address concerns raised by the Care Quality Commission during the year.

Possible areas for improvement next year:

- Including a glossary within the Quality Report and clear explanations throughout the various sections; and
- The readability level of the draft Quality Report could be improved. We have used the Flesch Readability software to calculate a score of 39.1, which is at the lower end of the readability spectrum (1-100) with 60-70 range being ideal. It can be difficult to improve readability given some of the mandated statements and wording but we are aware of some Foundation Trusts who have managed to do so.

# Performance indicator testing

# Delayed Transfers of Care

Our testing found no errors

	Trust reported performance	Target	Overall evaluation of our work
2013/14	3.19%	7.5%	B
2012/13	3.8%	7.5%	B

## Indicator definition and process

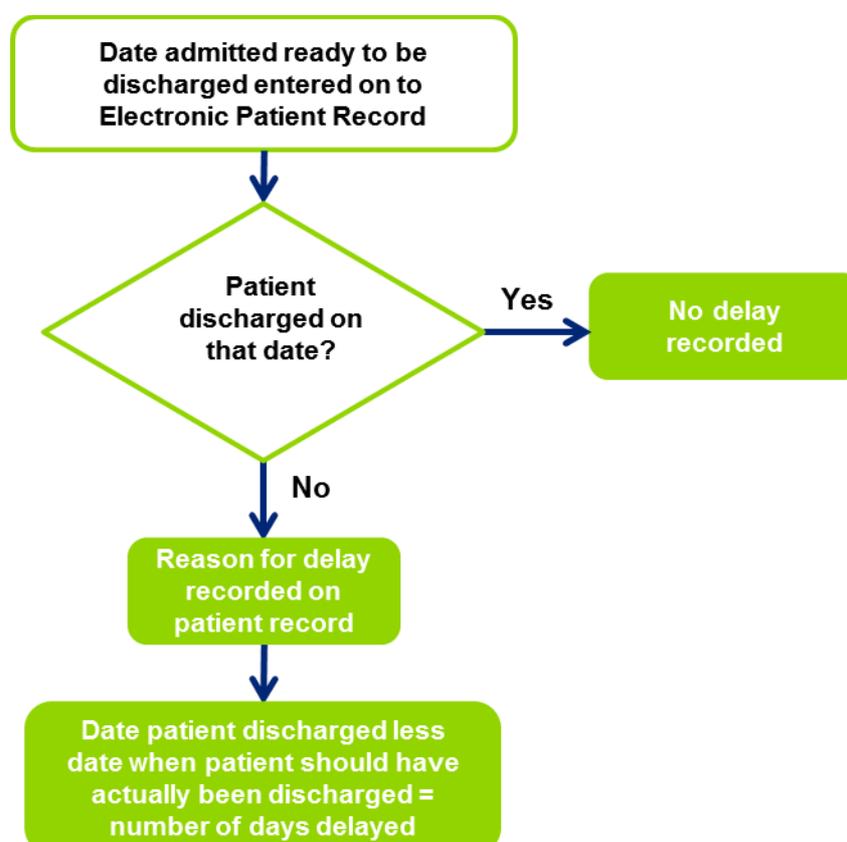
**Definition:** “The number of Delayed Transfers of Care per 100,000 population (all adults – aged 18 plus). A delayed transfer of care occurs when a patient is ready for transfer from a hospital bed, but is still occupying such a bed. A patient is ready for transfer when:

[a] a clinical decision has been made that the patient is ready for transfer AND

[b] a multi-disciplinary team decision has been made that the patient is ready for transfer AND

[c] the patient is safe to discharge/transfer.”

This indicator measures the impact of community-based care in facilitating timely discharge from hospital and the mechanisms in place within the hospital to facilitate timely discharge. People should receive the right care in the right place at the right time and mental health trusts must ensure, with primary care organisations and social services that people move on from the hospital environment once they are safe to transfer.



# Delayed Transfers of Care (continued)

## Approach

- We met with the Trust's leads to understand the process from an individual being ready to transfer care to the overall performance being included in the Quality Report. We also discussed the following recommendations from the prior year:
  - Amend the EPJS to flag the number of days of delay correctly; and
  - Ensure that the DH/Monitor definition is applied in full when reporting performance both internally and externally.
- We evaluated the design and implementation of controls through the process.
- We selected a sample of 24 from 1 April 2013 to 31 March 2014 including both delayed and delay free transfers of care.

## Findings

- The Trust has implemented prior year recommendations made by Deloitte, which can be found in more detail in the update section at page 15.
- We agreed our sample of 24 to the underlying information held within EPJS and found no errors.
- During our work, the Trust identified themselves that the quarterly performance calculation method being applied was incorrect. The Trust had incorrectly been including CAMHS into the performance calculation. As this was identified prior to the Q4 data being submitted to Monitor the Trust was able to correctly report Q4 performance. We have re-calculated the performance indicator based on the Monitor definition and have requested this figure to be included into the Quality Report (3.19%) and have seen this actioned.

### Deloitte View:

Our sample testing found no errors and our prior year recommendations have been implemented. The Trust identified an issue with the methodology being applied to the calculation of the performance indicator and therefore the performance data reported to Monitor and the Board during the year. Whilst we have agreed the now corrected figure within the 2013/14 Quality Report, we would highlight this issue to ensure that the accuracy of the calculation is maintained going forward.

# Access to Crisis Resolution Home Treatment Team

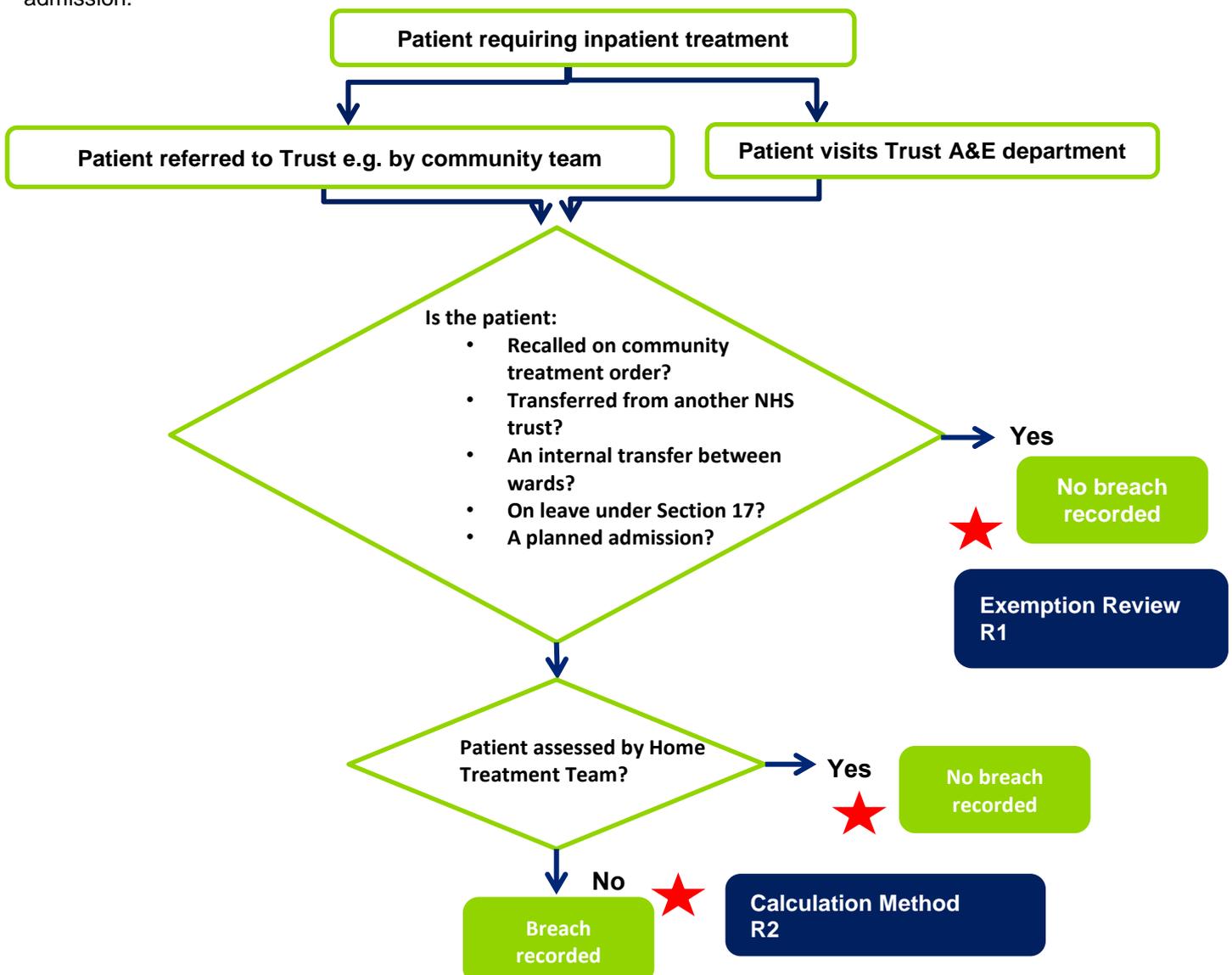
The Trust no longer applies local exemptions

	Trust reported performance	Target	Overall evaluation of our work
2013/14	94.12%	95%	B
2012/13	98.73%	95%	R

## Indicator definition and process

**Definition:** “The proportion of inpatient admissions gatekept by the crisis resolution home treatment teams.”

Crisis Resolution / Home Treatment Services form part of the drive to ensure inpatient care is used appropriately and only when necessary, with service users being treated in the community setting, where possible. They are to provide a ‘gateway’ to inpatient care and are deemed to have ‘gatekept’ an admission if they have assessed the service user before admission and they were involved in the decision making process, which resulted in full admission.

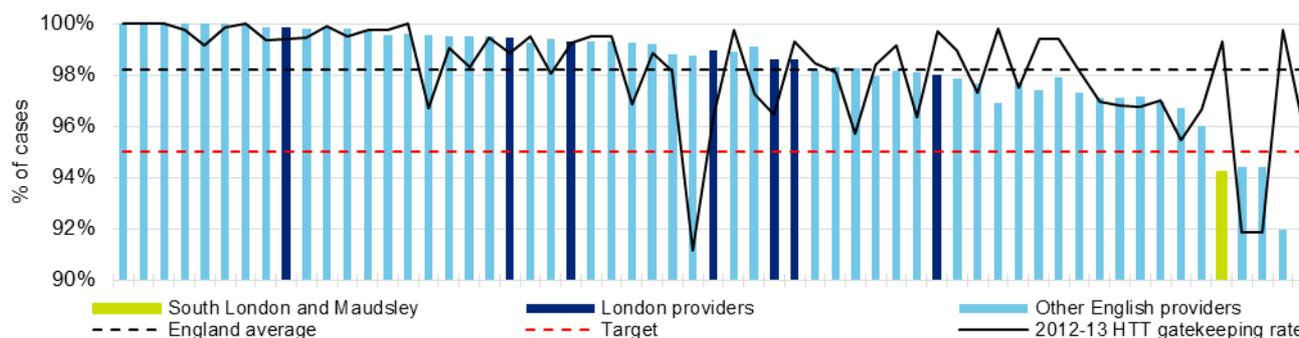


# Access to Crisis Resolution Home Treatment Team (continued)

## National context

The chart below shows how the Trust compares to other organisations nationally for 2013/14, based on the latest national data available from the Health and Social Care Information Centre, and reflects the reduction in performance once the Monitor definition had been applied.

### Inpatient admissions with access to Crisis Resolution/Home Treatment teams - 2013-14



Source: Deloitte analysis of Health and Social Care Information Centre data

## Approach

- We met with the Trust's leads to understand the process from identifying that a service user should have access to the crisis resolution team to the overall performance being included in the Quality Report. We also discussed recommendations from the prior year.
- We selected a sample of 24 from 1 April 2013 to 31 March 2014 including both service users assessed by the Home Treatment Team (HTT) and those who were not assessed. We agreed our sample to the underlying information held within EPJS.
- During our work we found 2 errors and therefore extended our sample by a further 6 cases. We found no further errors.

## Findings

- Our testing confirmed that the Trust has amended their approach to exemptions (as per our recommendation last year) at the end of Q1 and now apply only those exemptions within the Monitor definitions.
- This change in approach has led to a dip in performance and very few exemptions now being applied for this indicator.
- We found two minor errors in our testing of Q1 data, relating to the use of exemptions, but we determined that these were isolated cases. As the number of exemptions is now much reduced, we recommend that the Trust review those exempted cases to confirm accuracy. [See Recommendation 1.](#)
- As part of our work we also recalculated the performance indicator. We found that the Trust was including exemptions in both the numerator and the denominator in the calculation which is not consistent with Monitor guidelines. The resulting difference was minimal, however the Trust has amended their calculation method and we have agreed the performance figure within the 2013/14 Quality Report. [See Recommendation 2.](#)

### Deloitte View:

Last year we issued a modified limited assurance opinion based on the number of additional local exemptions that were applied over and above those specified within the Monitor definitions and guidance.

Our testing has confirmed that the Trust has improved its processes for reporting this indicator over the last year to now follow the Monitor definitions and guidance. Of the six dimensions of quality we found some issues with three: accuracy; validity; and completeness, and have made some recommendations for improvement.

# Local Indicator: Percentage of complaints relating to staff attitude

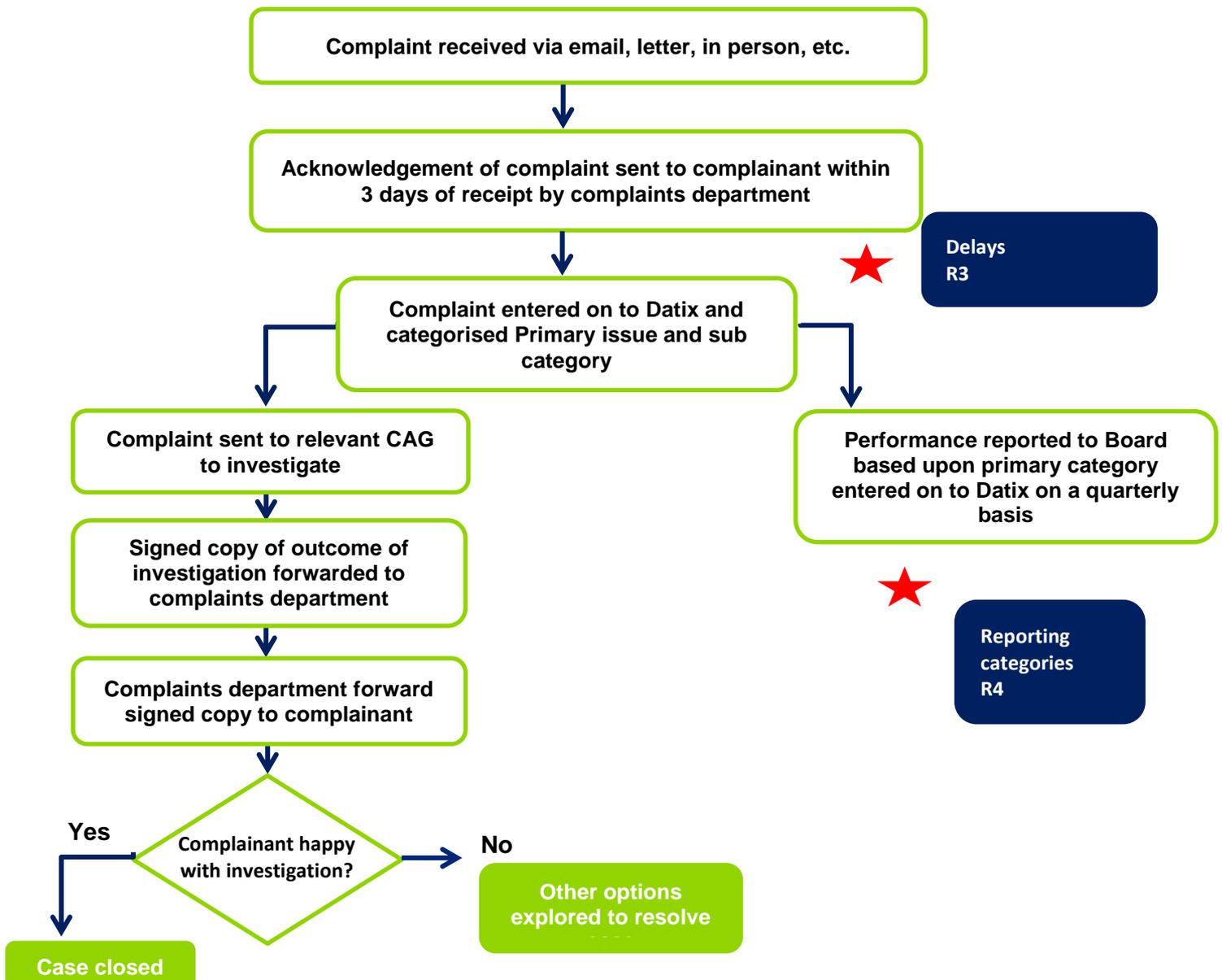
Complaint reports include the primary category only

	Trust reported performance	Target	Overall evaluation of our work
2013/14	17.6%	20%	B
2012/13	21.4%	No target set	

## Indicator definition and process

**Definition:** “The percentage of all complaints that are in relation to staff attitude.”

This target supports the principle of a ‘culture of compassion’ as recommended in the Francis Report. In 2013/14, the Trust focused on reducing the number of complaints about staff attitude. To achieve this, the Trust has run customer service training, promotion of the 5 SLAM Commitments, RCN Leadership Program and implementing the Privacy & Dignity policy throughout the course of the year.



# Local Indicator: Percentage of complaints relating to staff attitude (continued)

## Approach

- We met with the Trust's leads to understand the process around complaints, and what exactly is reported to the Board on a quarterly basis.
- Based on our understanding, we selected a sample of 24 from 1 April 2013 to 31 March 2014 to test the data. During our work we found no errors.

## Findings

- Whilst we did not find any errors that impacted on the quality of data underpinning the performance indicator, our testing found that there are often delays inputting the complaint onto the Datix system once a complaint had been received. This could potentially result in omission of complaints when calculating performance, thus giving an inaccurate conclusion. [See Recommendation 3.](#)
- When complaints are received and input onto Datix, the complaint is categorised with a primary category and a sub-category. This helps when the complaint covers a range of different matters such as care treatment and staff attitude. Using this example, the primary category would be care treatment and the sub-category would be staff attitude. From our work, we understand that it is only the primary category that is included in reports to the Board and therefore the Board may be receiving an incomplete picture of complaints regarding staff attitude. [See Recommendation 4.](#)

### Deloitte View:

Overall we found that the Trust has processes to generate a satisfactory quality of data underpinning the indicator. Of the six dimensions of quality we found some issues with two: timeliness and completeness, and have made some recommendations for improvement.

# Recommendations

# Recommendations for improvement

Our recommendations have been accepted by management

Indicator	Deloitte Recommendation	Management Response	Priority
Access to Crisis Resolution Home Treatment Team	<p><b>R1: Review all exemptions</b></p> <p>Given the small number of exemptions, management should review these to ensure that they are valid.</p>	<p>The Performance Team already has a process in place to do a random spot check in ePJS to ensure that proper evidence of HTT assessment or exemption is recorded. We will include an additional step to check the evidence behind all the exemptions. Given the small number of exemptions, it should be a relatively simple change in the process.</p> <p><b>Responsible Officer:</b> Roy Jaggon / Head of Performance Management</p> <p><b>Timeline:</b> Quarter 1, 2014/15</p> <p><b>Process for updating Council of Governors:</b> The Council of Governors (CoG) will be updated on the progress through the monthly CoG meeting.</p>	Medium
Access to Crisis Resolution Home Treatment Team	<p><b>R2: Performance calculation</b></p> <p>Review the calculation methodology for all performance indicators reported to Monitor and the Board to ensure that all performance indicators are calculated according to Monitor definitions and guidelines (both numerator and denominator).</p>	<p>We have already modified the calculation methodology for HTT, and we will work with Health Intelligence team to review the reports for other Monitor indicators to ensure that these adhere to Monitor guidelines and definitions.</p> <p><b>Responsible Officer:</b> Roy Jaggon / Head of Performance Management</p> <p><b>Timeline:</b> Quarter 1, 2014/15</p> <p><b>Process for updating Council of Governors:</b> The Council of Governors (CoG) will be updated on the progress through the monthly CoG meeting.</p>	High
Percentage of complaints in relation to staff attitude	<p><b>R3: Input data into Datix on a timely manner</b></p> <p>All complaints should be input onto Datix in a timely manner, once the complaint has been received.</p>	<p>New Team Administrator is now responsible for logging all formal complaints on to DATIX as they are notified to the complaints team. Arrangements for leave cover have been agreed</p> <p><b>Responsible Officer:</b> Mary O'Donovan</p> <p><b>Timeline:</b> From 1<sup>st</sup> June 2014</p> <p><b>Process for updating Council of Governors:</b> The CoG will receive a 6 and 12 month update against these recommendations through the CoG Quality Sub Group</p>	Medium
	<p><b>R4: Include sub-category when calculating performance</b></p> <p>Reporting performance of this indicator should include both the primary and subcategory, in order to give a more complete picture of performance.</p>	<p>Quarterly and annual complaints reports to Quality Sub Committee of the Board will include data for subcategories of the primary category - 'staff attitude and behaviour'</p> <p><b>Responsible Officer:</b> Mary O'Donovan</p> <p><b>Timeline:</b> From Q1 2014/15</p> <p><b>Process for updating Council of Governors:</b> The CoG will receive a 6 and 12 month update against these recommendations through the CoG Quality Sub Group</p>	High

# Update on prior year recommendations

Our prior year recommendations have been addressed.

Indicator	Deloitte Recommendation	Current year status
Delayed Transfer of Care	<b>Calculation of the period is 1 day to few</b> The system flags the first day of the delay following the day that the delay was discharged (therefore the day of discharge is day zero)	Issue has been resolved, and no further issues have been identified with respect to this in the current year testing.
Delayed Transfer of Care	<b>Excluding non-exempt patients</b> Trust was excluding patients under continuing care and forensic beds; however this exclusion was not included within the Monitor guidelines.	Issue has been resolved, and no further issues have been identified with respect to this in the current year testing.
Access to Crisis Resolution Home Treatment Team	<b>Exemptions not within Monitor guidelines had been applied.</b> The Trust was including exemptions that are not within Monitor guidelines in the performance calculation.	Issue has been resolved, and no further issues have been identified with respect to this in the current year testing.

# Data Quality Framework

# Data Quality Framework

## For evaluating the findings from our testing

### Overview

The volume and importance of non-financial performance information across the NHS has grown significantly in recent years. Performance reporting has emerged as a key tool used both internally and externally. Managers use information to monitor performance, regulators use it to gauge risk, commissioners use it to ensure their priorities are met, and governors, patients and the public use it to gain more information about their trust and to hold them to account.

Whilst the availability and use of non-financial performance information has developed quickly, the control frameworks used to produce and control such information has not been subject to the same level of rigour as that of financial information. On average a trust will receive information on 61 performance indicators on a monthly basis, but very few will be subject to independent review. This can result in a potential assurance gap.

In the table below we have prepared a summary of key considerations that each trust should be able to answer regarding their performance information. It can be used as an assurance tool to gauge the risk around accuracy and completeness of performance information.

Area	Overview	Key considerations
<b>System</b>	The accuracy of an indicator is influenced by the level of automated vs manual controls. In general, an automated system requiring minimal manual adjustment has a lower risk of error. However, this assumes that the system controls are operating as they are intended.	<ul style="list-style-type: none"> <li>Is the indicator generated from one system or the interaction of different systems?</li> <li>How often are system controls reviewed to ensure they are appropriate and meet indicator definitions?</li> <li>How quickly is data produced after the event?</li> <li>Does data require manual adjustment prior to being reported as a performance indicator?</li> </ul>
<b>Governance</b>	Accuracy and completeness of indicators are influenced by the 'tone at the top'. Good performance would mean clarity of responsibility for performance metrics, clear processes and procedures in place for each metric which are regularly updated, and quick and comprehensive action where concerns have been raised.	<ul style="list-style-type: none"> <li>Who is responsible for the quality and completeness of performance information at Board level?</li> <li>If different individuals are responsible for different indicators, is it clear who is responsible for each?</li> <li>Are there documented procedures and processes for each indicator and is this regularly updated?</li> <li>If data quality concerns have been raised have they been addressed quickly and comprehensively?</li> </ul>
<b>Inputs</b>	Some performance indicators rely on a wide variety of sources to produce the end metric. In general, the greater the number of separate sources of information, and the higher the volume of data, the greater the likelihood of error.	<ul style="list-style-type: none"> <li>What is the volume of inputs of each indicator on a daily / weekly / monthly basis?</li> <li>How many different sources of data are there, and how do you know they all apply consistently? methodology in collecting and reporting the data?</li> <li>What checks are in place to ensure the consistency and completeness of input data?</li> </ul>
<b>Complexity and skill</b>	Some indicators require specific skills to identify, analyse and report performance. Some indicators have complex rules, which requires specialist consideration. If the complexity of these rules is not understood and applied correctly, there is a risk that indicators contain errors or are reporting incomplete information.	<ul style="list-style-type: none"> <li>If performance indicators have specific rules, is there regular training to ensure that all individuals involved understand these rules and apply them correctly?</li> <li>Does the Trust have its own assurance systems in place to test compliance with such rules?</li> <li>Has the Trust got the appropriate skill and level of resources to identify, analyse and report performance for complex indicators?</li> <li>If national guidance is not clear, does the Trust have local guidance regarding process and procedures and is this shared with appropriate individuals?</li> </ul>

# Responsibility statement

# Purpose of our report and responsibility statement

Our report is designed to help you meet your governance duties

## What we report

Our report is designed to help the Council of Governors, Audit Committee, and the Board discharge their governance duties. It also represents one way in which we fulfil our obligations under Monitor's Audit Code to report to the Governors and Board our findings and recommendations for improvement concerning the content of the Quality Report and the mandated indicators. Our report includes:

- Results of our work on the content and consistency of the Quality Report, our testing of performance indicators, and our observations on the quality of your Quality Report.
- Our views on the effectiveness of your system of internal control relevant to risks that may affect the tested indicators.
- Other insights we have identified from our work.

## What we don't report

- As you will be aware, our limited assurance procedures are not designed to identify all matters that may be relevant to the Council of Governors or the Board.
- Also, there will be further information you need to discharge your governance responsibilities, such as matters reported on by management or by other specialist advisers.
- Finally, the views on internal controls and business risk assessment in our final report should not be taken as comprehensive or as an opinion on effectiveness since they will be based solely on the procedures performed in performing testing of the selected performance indicators.

## The scope of our work

- Our observations are developed in the context of our limited assurance procedures on the Quality Report and our related audit of the financial statements.
- This report should be read alongside the supplementary "Briefing on audit matters" circulated to you in December 2012.

We welcome the opportunity to discuss our report with you and receive your feedback.

*Deloitte LLP*

**Deloitte LLP**  
Chartered Accountants

29 May 2014

This report is confidential and prepared solely for the purpose set out in our engagement letter and for the Board of Directors, as a body, and Council of Governors, as a body, and we therefore accept responsibility to you alone for its contents. We accept no duty, responsibility or liability to any other parties, since this report has not been prepared, and is not intended, for any other purpose. Except where required by law or regulation, it should not be made available to any other parties without our prior written consent. You should not, without our prior written consent, refer to or use our name on this report for any other purpose, disclose them or refer to them in any prospectus or other document, or make them available or communicate them to any other party. We agree that a copy of our report may be provided to Monitor for their information in connection with this purpose, but as made clear in our engagement letter dated 26 March 2014, only the basis that we accept no duty, liability or responsibility to Monitor in relation to our Deliverables.

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**Attachment D**

**COUNCIL OF GOVERNORS – SUMMARY REPORT**

<b>Date of meeting:</b>	16 September 2014
<b>Name of report:</b>	Report from working groups
<b>Author:</b>	Paul Mitchell
<b>Presented by:</b>	Working group chairs

**Purpose of the report:**

To receive an update on the recent activity of the Working Groups:

- Quality
- Planning and Strategy
- Membership and Communications
- Bids steering group

## **REPORT FROM WORKING GROUPS**

### **1. Quality Group**

Chair - Dr Tom Werner

Noel Urwin and Dr Tom Werner have met with Lesley Calladine, chair of the Board Quality Committee. She outlined the forthcoming work programme. It was suggested that a nomination for a Governor to act as a participating observer at the Board Quality Committee should be made. This would comprise one nominee plus a deputy who would become the observer for the following year. It was agreed that Chris Anderson will be the participating observer with Tom Werner as the deputy.

Noel Urwin reported that a number of Governors had met with Deloitte. The key points noted were:

- Quality Account must be written for a wide audience.
- Delayed discharges - it was noted that re-admission rates were included in the Quality Account.
- CRHTT – the Trust was using the Monitor definition.
- Complaints relating to staff attitude were below the target.
- Deloitte had no concerns related to service quality.

Items for consideration at future meetings will be CQC inspections and the new quality strategy.

### **2. Planning and Strategy Working Group**

Chair - Angela Flood

As a Foundation Trust, the Council of Governors has a key role in commenting on the strategic direction of the Trust. The Planning and Strategy Working Group is intended to be a forum for cooperation and participation and members of the group represent the interests and views of different stakeholders. By sharing information, knowledge and expertise and by maintaining and strengthening lines of communication, the group will assist Governors to fulfil their responsibility for regularly feeding back information about the Trust's strategic vision and goals to the constituencies/classes and stakeholder organisations.

By the time our next meeting takes place on 6th October, the Group will have met quarterly during 2014.

The Director Organisation and Community and the Head of Strategic Planning and Equality attend all group meetings to provide information, advice and guidance as necessary.

The Group is fortunate in having Governor Members representing a range of Constituencies: service users; carers; staff and public, with the appointed Members representing key stakeholders. As well as representing the various constituencies, some Governors also Chair other key groups – the Quality Working Group, the Membership and Communications Group and the Bid Steering Group – enabling information sharing and interaction between key strategic and operational areas. In addition to the considerable organisational knowledge and long-standing experience

that our Lead Governor brings to the Group, members also bring a wide range of knowledge, skills, experience, perspectives and challenge to the Trust's strategic development.

Within a context of fast-paced transformational change and increased expectations internally and externally, the Group has actively contributed, individually and collectively, to the development of key areas including: establishing formal Terms of Reference for the Group ensuring clarity of aims, objectives and remit; review of Patient and Public Involvement including the Expanding Opportunities-Increasing Involvement Paper and EPIC (Engaging Patients Involving Carers); review of the Operational Plan 2014-2016 and the Strategic Plan 2014-2019 prior to ratification by the Board and submission to Monitor; participation at 4 cross-borough public events to support the active involvement of the Trusts stakeholders in the development of its future strategic direction. The Group has also gained approval to nominate a Governor to attend the Audit Committee, establishing a critical link between strategic development and the management of risk, financial management and governance, crucial to efficient and effective operational implementation.

The Group will continue to seek to benefit from the knowledge and expertise of other individuals and groups. By enabling interaction, collaboration and shared learning, the Planning and Strategy Working Group aims to support the Trust not only to address its current challenges, but also to achieve its stated objectives and future goals.

### **3. Membership and Communications**

Chair - Dr Dele Olajide

Membership numbers across London Mental Health Trusts were assessed. It was agreed to investigate the feasibility of holding a cross-Trust membership event to learn more about recruiting strategies.

The "Happy Heads" event had been held on 26 July. It was considered to be a very successful day with over 100 guests attending. 28 new members were signed up.

A programme to widen membership participation and staff awareness will be undertaken in future months. Long term targets were agreed to increase public membership to 1% of population (12,700 = double present) and increase service user / carer membership to 25% of those eligible (10,000 = eight times present). There was a requirement to improve the members' website page and link to blogs and provide a better forum for comments.

The new membership discount cards are being sent to all members during September.

A number of governor's terms are coming to an end in October and there are also vacancies in the staff, service user and public constituencies. It is recommended that an election process is commenced directly after the APM.

#### **4. Bids Steering Group**

Chair - Roger Oliver

An initial 344 expressions of interest were received which led to the submission of 194 bids.

A team of Governors and SLAM staff assessed all the bids over a day and a half and have scored them against a detailed template. The standard of bids has been noticeably far higher than other years.

On 8 September the Bids Group decided on who has been successful in this year's bids programme. Using a median to 15+, 125 bids would be successful at a cost of £88,362.11.

PNJM / September 2014

**Attachment E**

**COUNCIL OF GOVERNORS – SUMMARY REPORT**

<b>Date of meeting:</b>	16 September 2014
<b>Name of report:</b>	Chief Executive's Report
<b>Author:</b>	Paul Mitchell, Trust Secretary
<b>Presented by:</b>	Dr Matthew Patrick, Chief Executive

**Purpose of the report:**

To receive an update report from the Chief Executive on Trust and national issues.

## Chief Executive's Report

September 2014

### 1. Trust issues

#### Monitor update

Monitor has continued their investigation into how the Trust Board is performing following concerns expressed by external consultants. Over the summer monitor have been reviewing written materials provided in relation to questions asked. They also met with a number of members of the Council of Governors, including members of the Nominations Committee and Chairs of key sub-committees.

We remain in close dialogue with the regulator and have also responded to supplementary requests for further clarification and information. We are hoping that we should hear the outcome of the review towards the end of September.

#### SLaM goes smokefree

Staff, patients and all other visitors to SLaM will not be able to smoke anywhere on Trust sites, including all wards, buildings and grounds, from 1 October 2014. Patients who smoke will be supported through the change by staff.

People with mental health problems are more likely to smoke, and to smoke more heavily, than the general population and this is one of the reasons that they generally have poorer physical health and a lower life expectancy.

We want to help reduce this inequality by creating a smokefree environment across SLaM sites from 1 October 2014. This decision is in line with National Institute for Health and Care Excellence (NICE) guidelines which recommend that that all hospital sites, including mental health hospitals, should be 100 per cent smokefree.

Clinical staff across SLaM are currently training in smoking cessation interventions so that they have the appropriate skills and knowledge to support patients to stop smoking, either permanently or temporarily for the duration of their appointment or inpatient stay.

#### Integrated Care

Colleagues will recall that I am the nominated Senior Responsible Executive Officer for Integrated Care across KHP. One key task has been to establish a KHP integrated care office. Regular meetings have now been set up with a number held over August and work is progressing to identify key priorities and to align our contribution with that of Southwark and Lambeth Integrated Care (SLIC).

Work is also progressing within the Southwark and Lambeth Provider Group which I co-chair with Dr Tyrrell Evans, a local GP. The provider group comprises representation from Primary Care, Social Care, KHP and local citizens, and it has the task of developing the provider response to the commissioning challenge to develop more joined up models of care delivered closer to home and in a different form of partnership with local communities and neighbourhoods.

## 2. National issues

### **Chief medical officer calls for greater emphasis on mental illness**

England's chief medical officer has said that mental health needs to be more of a priority, with targets for waiting times and more protection for funding. Dame Sally Davies said there were signs funding was being cut at a time when the cost to the economy was rising. Her annual report said mental illness led to the loss of 70 million working days last year – up 24% since 2009. As well as calling for greater emphasis on mental illness in the NHS, she also recommended that employers offer flexible working to people with mental health problems to keep them in employment and maintain regular contact during sick leave. Dame Sally said access to services needed to improve, with young people in particular needing better access to support. At the launch event at the Royal College of Psychiatrists both SLaM and the IoP were very well represented. Graham Thornicroft gave one of the excellent keynote contributions, and our clinical academics were also very well represented in the authorship of key chapters within the report.

### **Only one third of depression cases treated**

Professor Sir Simon Wessely, the incoming president of the Royal College of Psychiatrists and Consultant Psychiatrist at SLaM, has highlighted that less than a third of people with common mental health problems receive any treatment. Sir Simon said people are still routinely waiting more than 18 weeks, possibly up to two years for treatment. He added that he strongly believed in the need for doctors, nurses, midwives and social workers to have more mental health training and for there to be much greater integration of diagnosis and treatment of physical and mental disorders.

### **Barker commission publish final report**

A single, ring-fenced budget for health and social care in England, one local commissioner for local services, and free social care for those whose needs are currently defined as 'critical' are among a set of recommendations made by the Barker Commission.

The independent Commission on the Future of Health of Social Care in England established by the Kings fund and led by Dame Kate Barker, have published their report "A new settlement for health and social care". The commission recommends moving to a single, ring-fenced budget for the NHS and social care and proposes funding changes, including changes to national insurance contributions, to meet the costs that would be required to improve social care entitlements.

### **The Department of Health publishes new scrutiny guidance**

The Department of Health has published guidance that explains local authorities' review and scrutiny responsibilities as set out in the Local Authority (Public Health, Health and Wellbeing Boards and Health Scrutiny) Regulations 2013 (Health Scrutiny Regulations) and the policy background to the scrutiny of local health services.

The guidance describes the changes that were made to local authorities' health scrutiny responsibilities by the introduction of the Health Scrutiny Regulations. The principal change was the extension of the scope of health scrutiny to cover providers of health services who are not NHS bodies, such as local authorities, GP practices, pharmacists, opticians, dentists, private and voluntary sector providers.

Key messages from the guidance are:

- Local authorities should proactively seek information about the performance of local health services and institutions, challenge the information provided and test

- the information by drawing on different sources of intelligence
- In the light of the Francis Report, local authorities will need to satisfy themselves that they keep open effective channels by which the public can communicate concerns about the quality of NHS and public health services to health scrutiny bodies
  - In the light of the Francis Report, local authorities will need to consider ways of independently verifying information provided to them by NHS bodies and relevant **health service providers – for example by seeking the views of Healthwatch.**

### **NHS rated as best healthcare system in the world**

In a report conducted by The Commonwealth Fund, the UK's health system has been ranked first overall in comparison with ten other countries in quality, efficiency, cost and performance. "Mirror, Mirror on the Wall," scores the UK highly for its quality of care, efficiency and low cost at the point of service, with Switzerland coming an overall second. The US came last, as it has done in four other editions of "Mirror, Mirror" since 2004. The Commonwealth fund is a Washington-based foundation respected for its analysis of the performance of different countries' health systems. It examined 11 countries, including detailed data from patients, doctors and the World Health Organisation. The full list of countries analysed in the study were: New Zealand, Australia, France, Germany, Norway, Sweden, the Netherlands, Switzerland, Canada, Britain and the US.

### **Plans to give patients funds to purchase their own care**

NHS England chief executive Simon Stevens has announced a major change of policy that could see billions of pounds of health service and local authority budgets handed to the most vulnerable patients to purchase health and social care services in the community after a care plan is agreed with their doctors. From April next year, frail elderly people, disabled children and those with serious mental illness or learning disability will be offered individual sums of money to spend on health and social care services. Mr Stevens said that it would help keep people out of hospital and ultimately save money. Some patients' budgets will be as little as a few hundred pounds, though most are likely to get more than £1,000.

### **Block contracts for mental health**

Monitor has signalled the end of block contracts currently used to fund NHS mental health providers as part of a major shakeup of the national payment system due to be introduced next year.

In a pre-consultation paper on the national tariff for 2015-16 the regulator said it wants the mental health clustering system to become the main driver of prices. It has also proposed developing a new set of mental health "currencies" as part of any future payment system.

The pre-consultation paper stated: "We expect providers and commissioners to use the adult mental health cluster currency for payment, unless they develop an alternative approach in accordance with the applicable rules, and to submit reference costs data based on the clusters."

Currently, mental health providers use 21 care clusters to categorise patients according to the severity of their condition and the services they might need. These are used to set prices and feed into the minimum mental health dataset designed to underpin a national payment system.

The paper provided a clear indication of the direction Monitor wants to see the mental health sector take, and follows years of delay and doubt over the development of payment by results for mental health services. The development of such a system has been beset by delays and fears over the quality of the data.

### **3. Congratulations**

#### **Nursing Times awards**

Director of Nursing at SLaM, Dr Neil Brimblecombe, has been honoured in the prestigious Nursing Times Leaders list. The award recognises Neil's work on safe staffing and his contribution to mental health strategy.

The list recognises individuals who have demonstrated strength across the five key areas of leadership outlined by the NHS Leadership Academy Healthcare Leadership Model. The five key areas are: leadership, influence, impact, role model and legacy. A list of over 200 people was put before a judging panel, and Neil was one of forty six people who made the final inaugural list.

#### **Director of NIHR BRC**

Following an international search, Professor Matthew Hotopf has been appointed Director of the National Institute for Health Research (NIHR) Biomedical Research Centre (BRC) at South London and Maudsley (SLaM) NHS Foundation Trust and the Institute of Psychiatry (IoP), King's College London.

Professor Hotopf has been with the BRC since its inception in 2007 and has acted as Interim Director since January 2014. From 2007-2012 Professor Hotopf led the BRC's Analytic Methodologies theme which developed the innovative Clinical Record Interactive Search (CRIS), the most in depth mental health data resource in Europe. CRIS is used for clinical research purposes and has now been deployed across four other mental health trusts in the UK. He also leads the South East London Community Health Survey, the largest study of urban mental health in the country.

Matthew has a proven track record of success and commitment to the BRC and his appointment will ensure that it remains under strong leadership and at the forefront of mental health experimental medicine and translational research.

#### **RCPsych awards**

The outstanding achievements of South London and Maudsley NHS Foundation Trust's (SLaM) staff have been recognised by the Royal College of Psychiatrists in their annual awards shortlist.

The awards, now in their sixth year, recognise and celebrate excellence in psychiatry and mental health services. The winners will be announced at the RCPsych awards ceremony in London on 6 November 2014.

Seven SLaM colleagues have been shortlisted for an RCPsych Award 2014:

- Dr Sarah Bernard for RCPsych Psychiatrist of the Year.
- Dr Sukhi Shergill for RCPsych Academic Researcher of the Year.

- Dr Fiona Gaughran for RCPsych Psychiatric Trainer of the Year.
- Dr Paola Dazzan for RCPsych Academic Researcher of the Year.
- Dr Alex Langford for RCPsych Core Psychiatric Trainee of the Year.
- Bridget Jones and Matthew McKenzie for RCPsych Carer Contributor of the Year.  
Matthew is an elected member of SLaM's Council of Governors.

### **National Psychosis Unit praised**

The Lancet Psychiatry praised the National Psychosis Unit, based at Bethlem Royal Hospital, for providing a great example for other countries to follow on integrating physical and mental health care.

The Unit specialises in treatment for people with complex and co-morbid psychosis, to enhance their quality of life through recovery and substantially reducing the risk of readmission.

In the August edition of the journal the unit is described as 'providing clinical care for patients with the most difficult to manage illnesses, the team undertakes research into the effectiveness of existing and new treatments and pioneers novel interventions'. A tremendous achievement and a testament to this organisations absolute commitment to the people we serve and the quality of support to which they are entitled.

### **Jo Brand honoured**

Jo Brand has been elected an Honorary Fellow of King's College London in recognition of her work as an advocate for people with mental health problems, support of mental health research and long-standing association with the IoP and SLaM.

**Dr Matthew Patrick**  
**Chief Executive**  
**September 2014**

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