South London and Maudsley NHS
NHS Foundation Trust

Quality Account for 2015/2016

DRAFT

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Part 1:

1.1 Statement on quality from the Chief Executive of the NHS Foundation Trust

The annual quality account report is an important way for the Trust to report on quality and show improvements in the services we deliver to local communities and stakeholders.

This year saw a comprehensive inspection across 11 service areas which included 71 wards, teams and clinics across all the trust's sites by the Care Quality Commission (CQC). The inspection involved more than 100 inspectors which judged services to be "safe, effective, caring, responsive and well led. The trust has much to be proud of and to receive an overall rating of 'good' reflects the commitment, talent and compassion demonstrated by our staff day in, day out.

Out of 11 services, inspectors rated those for people with a learning disability or autism as 'outstanding'; six as 'good', including specialist community and inpatient services for children and adolescents; and three services as 'requires improvement'. Delivering mental health services within large, complex and often deprived inner city communities is challenging. All trusts in this position are committed to addressing these challenges and improving their services, especially for patients in crisis.

We are working constantly to improve our care and there are still some significant areas that we need to improve. The CQC's report has provided us with an agenda and action plan for making these necessary improvements. It has also helped in forming the basis of discussions with our local commissioners, service users and other key stakeholders when agreeing our priorities for this year.

The CQC's publication of its rating and full report can be found at the following website: http://www.cqc.org.uk/provider/RV5

To our best knowledge the information presented in this report is accurate and I hope you will find it informative and stimulating.

Dr Matthew Patrick
Chief Executive Officer

1.2 A summary of successes and developments in 2015/2016

AREA	SUCCESS/DEVELOPMENTS
Care Quality Commission (CQC)	➢ Achieved an overall Inspection rating of 'Good'. ➢ In June 2015 praised Lambeth's mental health services as an example of how to support people experiencing a mental health crisis.
ICT/Technology	➢ SlaM is working with technology partners to develop an in-house virtual reality environment where service users can challenge their OCD. ➢ We are the number one NHS Trust to adopt cloud services with over 3500 staff migrated to Microsoft Office 365 with a further 1400 on line shortly. ➢ SLaM is developing with partners, MioCare, open source eOBs technology to enable paper free patient observations. Following a pilot at Bethlem Royal Hospital SLaM made a successful bid to fund this project across inpatient areas. ➢ We can now share both physical and mental health records with our Academic Health Sciences Centre partners; Guy's and St Thomas', King's College Hospital.
Service Development	➢ The opening of a 24/7 Crisis line which is operated 24/7 by mental health professionals was launched in December 2015. ➢ Opening of the Bethlem Hospital's new Gallery and Museum space in the original hospital administration building.
Research	➢ Born out of the Maudsley's Biomedical Research Centre (BRC) the Centre for Translational Informatics provides a research and clinical informatics environment delivering real-world improvements to patients and clinicians in partnership with King's College London. The CTI provides a functional interface between analytics, software development and implementation to promote digital innovation in mental health.
Awards/Creditations	➢ Two adult mental health wards at Bethlem Royal Hospital, won the quality of care category a top HSJ patient safety award, for their work

	with carers this year. ➢ The Centre for Interventional Paediatric Psychopharmacology & Rare Diseases within SlaM won an RCPsych Award in the category Psychiatric Team of the Year: children and adolescents. ➢ The mental health street triage service was set up to help thousands of people with mental health problems who come into contact with the capital's front line police officers every year. On 16 September it won an NHS Lambeth Clinical Commissioning Group Lammy award in the 'working together' category. ➢ SLaM has been rated as the best hospital trust in the country for dementia care. An in-depth report, released in August 2015 by the Health and Social Care Information Centre (HSCIC), showed SLaM scored an impressive 98.4 points out of 100 in terms of how well we are established to deal with people with dementia and is top of a league table for all trusts in the country. ➢ Healthwatch England recognised SlaM's Channi Kumar Unit as being an example of 'where the NHS gets it right'. The 'Safely Home' report explains how at our unit 'mothers with complex mental health conditions work with staff to establish a relationship with their child and enable them to have a graduated discharge, ensuring they are prepared for a lasting return into the community'. ➢ In July 2015 the Trust was chosen as one of the best 100 places to work by the Health Service Journal (HSJ), recognising how we are working hard to create and maintain an environment where people can enjoy their work.

Table one: A summary of successes and developments in 2015/2016

1.3 …..and what we can do better.

- We need to improve in the three service areas that the CQC inspectors judged to require further improvement, the main issues for improvement highlighted were: staff recruitment and retention; improving the recording of risk for individual patients; the need to improve practices relating to restraint and seclusion; maintaining emergency medical equipment; and improving some environments to make them safer for patients.

- Where we did not achieve the quality priority target or indeed did not do as well as we had hoped, the priority has been rolled over to this year or are being monitored via other assurance processes such as Commissioning for Quality and Innovation (CQUINS).

- The effective documentation and use of Risk assessments needs improving and was highlighted as an issue with the CQC.

- We need to reduce the incidence of restraint, particularly prone, and improve recording. We hope to do this by continuing to roll out the four steps to safety and Implementation of the Safe and Therapeutic Services strategy.

- The role of the Carer is important and as such we need to improve the number of identified carers who are offered a carers assessment and associated care plan. We hope to do this by further Implementation of Carers strategy and a review of carer assessment documentation across 4 boroughs

All these have been translated into quality priorities for 2015/16.

Part 2: Priorities for Improvement and statements of assurance from the Board

2.1.1 Our priorities for improvement for 2016/2017

Over the last year we have listened to feedback from service users, their families, carers and our staff, as well as commissioners and regulators. This feedback alongside the CQC visit in September 2015 has helped us to identify our future priorities. This process of gathering feedback has included:

- Trust Quality Summit held on the 20th January 2016 with CQC, Commissioners and Stakeholders outlining CQC final feedback and results.
- Improving Quality and the CQC event for all Trustwide staff on the 2nd November 2015.
- Listening to questions, concerns and complaints from patients and their families and carers. A special thanks to the Dragon Café.
- Asking for feedback from service users from clinical areas on various sites.
- Listening to staff at Trust-wide events including the Trust-wide Annual conference and the Team Leader day.
- Receiving reports on our services from the Care Quality Commission, following inspections of our services.
- Listening to the views of commissioners at contract, quality and serious incident monitoring meetings.
- Listening to the views of the Health Overview and Scrutiny Committees of Lambeth, Southwark, Lewisham and Croydon.
- Listening to the views of Healthwatch in each of our four main boroughs.
- Reviewing audit results, research findings, service reviews and assessments and service user surveys.
- Continuing discussions with a quality working group of the Council of Governors which has looked at quality issues over the year.
- We have also reviewed national guidance and service quality themes and issues which are emerging nationally.

2.2.2 Care Quality Commission (CQC); Inspection September 2015 Results and Actions

SLaM is required to be registered with the CQC and its current registration status is registered, without condition. The CQC has not taken enforcement action against SLaM during the period 2015/16.

The grid below outlines the results of the comprehensive inspection of some our services by the CQC on 21-25 September 2015.

	Safe	Effective	Caring	Responsive	Well led	Overall
Community mental health services for people with learning disabilities or autism	Good	Outstanding ☆	Outstanding ☆	Good	Outstanding ☆	Outstanding ☆
Mental health crisis services and health-based places of safety	Requires improvement	Good	Good	Good	Good	Good
Long stay/rehabilitation mental health wards for working age adults	Requires improvement	Good	Good	Good	Good	Good
Wards for people with learning disabilities or autism	Good	Outstanding ☆	Outstanding ☆	Good	Outstanding ☆	Outstanding ☆
Forensic inpatient/secure wards	Requires improvement	Good	Good	Requires improvement	Good	Requires improvement
Specialist community mental health services for children and young people	Good	Good	Good	Good	Good	Good
Acute wards for adults of working age and psychiatric intensive care units	Inadequate	Requires improvement	Good	Good	Requires improvement	Requires improvement
Wards for older people with mental health problems	Requires improvement	Requires improvement	Requires improvement	Requires improvement	Good	Requires improvement
Child and adolescent mental health wards	Good	Good	Good	Good	Good	Good
Community-based mental health services for adults of working age	Requires improvement	Good	Good	Good	Good	Good

Whilst the inspection highlighted much to be proud of there were also areas that both the CQC and the Trust recognised needed improvement and following the visit Action plans have been drafted and currently being implemented within the timeframes submitted. Below is a summary of the quality improvement work currently being undertaken.

Area of Improvement	Issues	Actions
Risk Assessments	Consistent completion, sufficiently detailed, responsively up dated, recorded in right place, linked to actions	•Redesign of ePJS •EObs project •Revising and strengthening training •Ongoing audit
Food	Responding better to individual and cultural need (Particularly Forensic and Older Adult Wards)	•New menu developed •Improve menu booking •Retendering of catering contract •Tighter monitoring and feedback •Regular patient feedback, centrally collated
Reducing Restraint	Reducing incidence of restraint, particularly prone, and improving recording	•Improve detail/process of reporting (complete) •Complete Trust Violence Reduction Strategy (including NICE guidance) •Roll out 4 Steps to Safety on all inpatient wards •Review training to ensure best practice and emphasis on accurate recording
Environmental Safety	Ensuring specific risks are managed including fire precautions and ligature risks	•Specific actions for PoS, ES1, Heather Close •Completion of ligature reduction programme •Visual management - audit of environmental risks
Equipment Safety	Consistent access to ligature cutters and timely checks on all equipment	•Review of emergency equipment standards •Improved audit processes re: equipment •Centralised online equipment audits to improve governance
Staffing	Sufficient staff available on acute wards, staff fully confident to work with people with dementia on Older People's Wards	•Continue current focus on recruitment, including focused reward schemes •Continue to develop new and innovative workforce models •Improved vacancy adverts and social media campaigns •Outdoor recruitment campaign (e.g escalators at Waterloo Underground) •Process improvements in recruitment system – speedier and more efficient to reduce delays •Increase in notice periods •Review of training needs in Older Adults services
Ensuring Inpatient's rights	Ensuring that privacy and dignity needs are sensitively met, that informal patients are fully aware of their rights and that blanket restrictions do not prevent individual needs being met.	Standards to be developed and audited re: observation windows on bedrooms •Development of standardised information re: informal patient rights which will be made fully visible and available in different forms on relevant wards •Review of restrictive practices on Rehabilitation Wards to ensure individual needs can be met

Table Two: CQC Actions

2.3 Our Quality Priorities for 2016/17

The priorities for 2016/2017 have been arranged under three broad headings which, put together, provide the national definition of quality in NHS services: patient safety, clinical effectiveness and patient experience. Progress on achievement of these priorities will be reported on in next year's Quality Accounts.

Patient Safety Priorities

1.Patient Safety Priority (This is a new priority)	
Quality Priority	To reduce the use of restrictive interventions applied to service users within in-patient settings.
Rationale	CQC action Positive and Safe initiative DoH (2014), NICE guidance and CQUIN
Target	Reduce any use of restraint that includes prone restraint.by 20%. Baseline: 220 in Q4/2016
Measure	Datix incidents in Q4/2017
How we will achieve this	Implementation Safe and Therapeutic Services strategy Roll out of Four steps to safety

2.Patient Safety Priority (This is a new priority)	
Quality Priority	To ensure that in-patient services have adequate staffing levels to provide safe and effective care.
Rationale	National Quality Board guidance CQC action
Target	To reduce the number of wards breaching agreed Trust minimum safe staffing levels by 30%. Baseline:15 Wards
Measure	Safer staffing monthly returns - Safecare
How we will achieve this	Process and system improvements to recruitment Improved advertising Efficient use of e-roster

3.Patient Safety Priority	
Quality Priority	To improve rates of completion of risk assessments and associated risk management plans for all service users requiring risk assessment.
Rationale	CQC action Serious incident reviews.
Target	85% of service users in in-patient services and community service users under CPA will have a full risk assessment completed for each in-patient admission or CPA review. Baseline:78%
Measure	This will be measured through clinical audit in Q4/ 2017.
How we will achieve this	The risk assessment tools within PJS are currently being reviewed in order to improve the efficiency of use. Clinical risk training

Clinical Effectiveness Priorities

4. Clinical Effectiveness (Enhanced priority)

Quality Priority	To provide effective physical healthcare assessment and intervention for in-patient service users, early intervention service users and community service users on CPA related to the cardio-metabolic risks associated with severe mental illness.
Rationale	CQUIN, CQC action, Parity of esteem
Target	90% of both in-patients service users and early intervention service users. 50% of community service users on CPA audited will have had an assessment of each of the key cardio metabolic parameters and offered interventions based on need. Baseline:85.4% Inpatients; Community Zero baseline(new scope)
Measure	Audit for CQUIN submission in Q4/2017 Baseline: Inpatients 85.4%, Community (no baseline,- new priority)
How we will achieve this	EPJS review Electronic observations roll out

5.Clinical Effectiveness Priority

Quality Priority	To ensure that service users are involved in the planning of their care and there are personalised care plans.
Rationale	CQC action Service user feedback
Target	>89% of service users will state that they feel involved in their care.
Measure	This will be measured through the patients survey results in response to the question 'Do you feel involved in your care?' Baseline Figure: 89%
How we will achieve this	Development of care planning standards and training review Review documentation within PJS to ensure that care planning is effective for service users and staff.

6.Clinical Effectiveness Priority (This is a new priority)

Quality Priority	We will develop our electronic systems to improve the delivery of care
Rationale	Improve consistency, efficiency and effectiveness of physical and mental health observations.
Target	50% of inpatient teams using electronic observations in practice Baseline: 0 Wards.
Measure	No. of wards using eobs
How we will achieve this	Roll out of eobs project across all inpatient wards.

Patient Experience Priorities

7.Patient Experience Priority (This is a new priority)

Quality Priority	Reduce the number of Acute out of area treatments (OATs) to ensure that service users are cared for closer to home.Reduce the number of external placements to ensure that service users are cared for closer to home.
Rationale	Service user feedback Crisp report on acute care pathway, Feb 2016
Target	A reduction in the number of adult patients admitted to external providers (overspill). Baseline Figure: awaiting data validation.
Measure	This will be measured in monthly performance meetings and data extracted.
How we will achieve this	The Trust Acute Transformation programme has an overspill reduction plan which is addressing the immediate reduction of out of area treatments (OATs).

8.Patient Experience Priority

Quality Priority	Identified carers will be offered a carers assessment and associated care plan.
Rationale	NICE guidance for Psychosis and Schizophrenia in adults. Service user and carer feedback. Care Act (2014) CQC action
Target	>50% of identified carers will have been offered a carers assessment and a carer's care plan. Baseline Figure: 32%
Measure	This will be measured through internal audit.
How we will achieve this	Further Implementation of Carers strategy Review of carer assessment documentation across 4 boroughs

9.Patient Experience Priority (Enhanced priority)

Quality Priority	We will continue to improve the quality of the environments and food within our in-patient services.
Rationale	CQC action Service user feedback.
Target	Patient Led Assessments of Care Environments (PLACE) and Food audit scores will achieve overall > 89.95%. Baseline 89.95% (food)
Measure	PLACE audit reports and hotel services Spot Light reports will be monitored and reviewed.
How we will achieve this	The full redesign of some clinical services is underway (e.g. Douglas Bennett block). Ligature reduction programme – window replacement Refurbishment programme. Food contract renewal

2.4 Audit

2.4.1 Participation in National Quality Improvement Programmes

National quality accreditation schemes, and national clinical audit programmes are important for a number of reasons. They provide a way of comparing our services and practice with other Trusts across the country, they provide assurances that our services are meeting the highest standards set by the professional bodies, and they also provide a framework for quality improvement for participating services.

During 2015/16, five national clinical audits and one national confidential inquiry covered NHS services that the South London and Maudsley NHS Foundation Trust provides.

During that period SLaM participated in 100% of national clinical audits and 100% of national confidential inquiries which it was eligible to participate in.

The national clinical audits and national confidential inquiries that SLaM was eligible to participate in during 2015/16 are listed below:

- The 3 national, Prescribing Observatory for Mental Health - POMH-UK audits:
    - Antipsychotic prescribing in people with a learning disability
    - Prescribing for ADHD
    - Prescribing valproate for bipolar disorder
- The CQUIN 2015/16 Indicator 4a: Improving Physical Healthcare to Reduce Premature Mortality in People with Severe Mental Illness (SMI)
- The Early intervention in Psychosis Audit (2015/16)
- The national confidential inquiry into suicide and homicide by people with mental illness

The national clinical audits that SLAM participated in for which data collection was completed during 2015/16, are listed below.

POMH-UK audits

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

SLAM pharmacy has collected and submitted data for the 2015-16 POMH-UK audits, as required.

- Antipsychotic prescribing in people with a learning disability
- Prescribing for ADHD
- Prescribing valproate for bipolar disorder

Below is a summary of the findings from those audits:

i) Antipsychotic prescribing in people with a learning disability

People with a learning disability prescribed an antipsychotic should have the indication for treatment documented in their notes. Results in 2015 showed that SLaM scored above average

in the national sample for the documentation of treatment in notes for people with a learning disability being prescribed antipsychotics.

In addition, patients should be assessed for known side effects of antipsychotics. Initial results showed SLaM as being below the national average. However, the 2015 re-audit showed SLaM to be above the national average with regards to the assessment of side effects.

Actions: The BPAD CAG has reviewed the data and these data have been presented at the trust DTC. A quality improvement programme is currently underway, led by the BPAD CAG, with support from pharmacy.

ii) Prescribing for ADHD

Children prescribed medication for ADHD should have their physical health monitored before starting treatment and at least once a year during maintenance treatment. Results of the 2015 re-audit indicated the presence of a physical health assessment at the commencement of treatment for all patients. SLaM was below the national average with regards to having all 4 measures documented.

With regards to physical health assessments during maintenance, SLaM was below the national average.

Actions: The CAMHS CAG has reviewed the data and these data have been presented at the trust DTC. A quality improvement programme is currently underway, led by CAMHS CAG with support from pharmacy.

iii) Prescribing valporate for bipolar disorder

Data for this audit have been submitted. The report is due later this year. Pharmacy introduced a quality improvement programme before data collection. Clinicians and patients were reminded of the risks of valproate in pregnancy. Pharmacy identified all women of child-bearing age currently prescribed valproate in the trust and asked clinicians to review the prescription of valproate in these women. Pharmacy informed women who continued treatment of the risks of valproate in pregnancy and the need for adequate contraception.

v) CQUIN Indicator 4a: Improving Physical Healthcare to Reduce Premature Mortality in People with Severe Mental Illness (SMI) 2015/16

The Trust participated in data collection and entry onto the NHSE online Webform Portal over a period of five weeks during December 2015 and January 2016. Confirmation was received from the Royal College of Psychiatrists. Results from the audit are pending.

vi) Early Intervention in Psychosis (2015/16) (HQIP)

The Trust participated in data collection and submission as required onto the NHSE online Webform Portal during December 2015 and January 2016. Results of the audit are due in April 2016.

The national confidential inquiry that SLAM participated in, for which data collection was completed during 2015/16, is outlined below:

i) National Confidential Inquiry into Suicide and Homicide by People with Mental Illness (NCISH)

The Trust Participated in the NCISH. Data for the NCISH reviewed suicide data over a 10 year period (2003-2013). Following the NCISH the Trust completed a themed review of all suicides over a three year period (outlined in the Trust clinical audit Programme below).

Results received in 2015/16 from data collected in 2014/15

National CQUIN Indicator 4a: Improving Physical Healthcare to Reduce Premature Mortality in People with Severe Mental Illness (SMI) 2014/15

Over a period of six weeks in December 2014 and January 2015 the Trust collected and entered (onto the NHSE online Webform Portal) data for the National CQUIN audit. The Trust was assessed against the following parameters:

Recorded assessment and interventions for the following:

1. Smoking status
2. Lifestyle (including exercise, diet alcohol and drugs)
3. Body Mass Index
4. Blood pressure
5. Glucose regulation (HbA1c or fasting glucose or random glucose as appropriate)
6. Blood lipids

Performance was calculated by NHSE based on the following:

A. The denominator will be the total number of patients in the sample.

B. The numerator will be the total number of patients in the sample for whom there was documented evidence that:

- they were screened for all six measures listed in the CQUIN guidance during their inpatient stay; and
- where clinically indicated, they were – by 28th November 2014 – directly provided with, or referred onwards to other services for interventions for each identified problem (with thresholds for intervention being as set out in NICE guidelines).

Feedback was received from NHSE by SLaM in April 2015 indicating the following compliance:

Organisation name	Number of forms received	% refusal to undergo screening	Analysis 1 Final % score
South London and Maudsley NHS Foundation Trust	100	4.71	**83.00**

2.4.2 Trust Clinical Audit Programme

The reports of 31 local Trust wide clinical audits were reviewed by relevant Committees and the SLaM Quality Sub Committee in 2015/16 and a number of actions have been taken to improve the quality of health care provided. Here are descriptions of four of them:

- **Suicide Prevention: Themed Review of Suicides in SlaM in a Three Year Period**

Following the National Confidential Inquiry into Suicide and Homicide the Clinical Audit and Effectiveness Team completed a review of all Suicides within SlaM over a three year time period (April 2012-March 2015). Audit findings were similar to the NCISH with respect to demographics and method of suicide. Of note is that:

- The suicide ratio between men and women was found to be smaller within SlaM although a higher ratio of male suicides was still present.
- The percentage of associated substance and/or alcohol usage was much lower within SlaM (17%) than National Data (59% history of alcohol misuse, 44% history of substance misuse).

Main themes identified were: Staff communication, clinical record keeping, risk assessment, care planning, staff training and policy review.

Following the audit, results were presented at the Quality Sub Committee. Some of the actions taken forward have been:

- The Clinical Risk Assessment and Management of Harm Policy has been reviewed and risk Assessment Proformas are being redesigned on ePJS
- The Self-harm and Carers re-audits are underway
- Meetings have been arranged with all CAGs to attend to review their NCISH gap assessment and action plan and to formalise trust action plan
- A meeting has been held with CCGs to discuss population based approach to suicide reduction. Further meetings are to be scheduled with each CCG Chair.
- All ligature audits on inpatient wards were completed in 2015.
- An 189 month Estates and Facilities Ligature Reduction Programme has been completed.

- **What Lessons are Being Learnt from Complaints in SLaM?**

  Themes resulting from Complaints was re-audited by the SlaM Corporate Audit Team in October 2015. Prominent themes were identified as: Communication with service users, Communication with family, Staff training, Carers and Clinical Records.

  Cross over is found between the thematic review of complaints and the thematic review of suicides in the themes/policy areas: communication with service users, staff training and clinical records.

  Following the audit

  - there is on-going work on the Experience CQUIN which focusses on Carers, the Family and Carers strategy 2015-2019 has been approved by the Board and a Carers re-audit has been commenced.
  - The report has been disseminated to CAG Projects Officers and Service directors directly for consideration in future Policy and Improvement work.

- **Pressure Ulcers: Assessment and Management of Pressure Ulcers in SLaM**

An audit of Pressure Ulcers within SlaM was completed in two parts. Part One measured assessment for the risk of pressure ulcers within SLaM. Part Two measured assessment and management of all identified pressure ulcers over a one year period. Following the completion of the audit:

- A presentation was given to the Physical Healthcare Committee.
- CAG specific data was written up in separate reports and sent to the relevant CAGs.
- Guidelines for wound management in the Mental Health of Older Adults CAG were created.
- A major Policy review is in progress with a focus on expectations for individual CAGs, this is to be tabled at the Physical Health Committee in July 2016.

- **Addressing Culture in Care Planning**

Following the Audit on Culture in Care Planning 2015:

- Results were presented and discussed at the Equality and Human Rights group.
- The audit was disseminated via a Purple Light Bulletin to CAG Project Officers and Service Leads this was also advertised on SLaM e-news. The Purple Light Bulletin included links to guidance on recovery and support care planning, NICE Guidelines and contact details for the Trust Equalities Manager.
- Questions on ethnicity and religious belief have been included in new integrated assessment.

2.5 Patients participating in research

The number of patients receiving NHS services provided or sub-contracted by the South London and Maudsley NHS Foundation Trust (SLaM) for the reporting period, 1 April 2015 - 31 March 2016, that were recruited during that period to participate in research approved by a research ethics committee was **3879.**

2.6 Commissioning for Quality and Innovation (CQUIN)

As last year, 2.5 % of SLaM income in 2015/16 is conditional on achieving quality improvement and innovation goals agreed between SLaM and any person they entered into an agreement with for the provision of relevant health services, through the Commissioning for Quality and Innovation payment framework. The value of these payments for 2015/16 was £5.8m.

2.7 Hospital Episode Statistics Data – HES

SLaM submitted records during 2015/16 to the Secondary Users services for inclusion in the Hospital Episode Statistics which are included in the latest published data.

The percentage of records in the published data:

	In-Patients - SUS data Apr 2015/ Feb 2016	Out-patients and Community –MHMDS Apr 2015/ Jan 2016 (provisional)
NHS No	98.5%	99.4%
GP Practice code	99.6%	98.5%

Table 3. The percentage of records relating to patient care which included the patient's NHS No and GP practice code.

2.8 Information Governance

The trust's submission for the annual HSCIC information governance toolkit for 2015-16 demonstrated 89% compliance with national health and social care information governance standards (al Level 2 or above), which is satisfactory compliance. SLaM annual submission was independently assessed by internal audit with a significant assurance outcome.

The Trust continued to implement improvements around information governance compliance with national standards and key legislation. There have been a number of initiatives to implement the recommendations of the Department of Health Information Governance Review (Caldicott 2). Following the implementation of KHP Online, which provides instant sharing of relevant patient information between care professionals to support direct provision of care within King's Health Partners, primary care providers in Lambeth and Southwark were included in the

same secure electronic platform to enable integrated care bringing together primary care, physical and mental health information in real time to residents in these boroughs.

Myhealthlocker is the trust's personal health records system which provides service users online access to relevant information about their treatment, care, condition and medication. MHL aims to bring patients to the centre of the discussions and decisions of their care and treatment by eroding sufficient, clear and relevant information about their mental health. The implementation of this system is underway with frequent consultations with service users in terms of the acceptable use, privacy, functionality offered by this platform to support patient centred care.

The Trust continues to provide clear, concise and up-to-date notification material to service users to ensure they are sufficiently information about the way their personal data is utilised with opportunities to opt-out of any scheme if they wish to do so.

2.9 Payment by Results Clinical Coding

SLaM was not subject to payment by results clinical coding audit by the Audit Commission during the 2015/2016 financial year.

There has been development this year to improve the completeness and accuracy of the Mental Health Clustering Tool which may become the payment by results currency in mental health. The Clinical Information System has built in alerts to remind clinicians that a mental health cluster has expired and reminder email alerts are additionally sent out on a regular basis.

2.10 Improving Data Quality

SLaM will be taking the following actions to improve data quality:

- Data Quality of MHSDS and other external submissions are routinely checked prior to the submissions.
- Business Intelligence is in the process of designing an array of solutions and systems aimed at supporting clinicians to improve the data quality.
- A rigorous Quality Assurance process has been implemented.

2.11 National indicators 2015/2016

NHS Outcome Framework Indicators

SLaM is required to report performance against the following indicators:

1. Care Programme Approach (CPA) 7 day follow-up
2. Access to Crisis Resolution Home Treatment (Home Treatment Team Gatekeeping)
3. Re-admission to hospital with 28 days of discharge
4. Service Users Experience of Health and Social Care Staff
5. Patient safety incidents resulting in severe harm or death

2.11.1 Care Programme Approach (CPA) 7 Day follow- up

Follow up within seven days of discharge from hospital has been demonstrated to be an effective way of reducing the overall rate of death by suicide in the UK. Patients on the care programme approach (CPA) who are discharged from a spell of inpatient care should be seen within seven days.

National Target	SLaM 2013/14	SLaM 2014/15	SLaM 2015/16	National Average 2015/16	Highest Trust % or Score 2015/16	Lowest Trust % Score 2015/16
95%	96.9%	97.4%	**96.99%**	96.9%	100%	50%

Table four. Seven day Follow-up
The lowest/highest and National Average scores (for a Trust) are based on the Q1-3 scores in 2015/16 published at the time of writing the quality account available at www.england.nhs.uk/statistics

2.11.2 Access to Crisis Resolution Home Treatment (Home Treatment Team)

Home treatment teams provide intensive support for people in mental health crisis, in their own home. Home Treatment is designed to prevent hospital admissions and give support to families and carers.

The indicator here is the percentage of admissions to the Trust's acute wards that were assessed by the crisis resolution home treatment teams prior to admission.

	National Target	SLaM 2013/14	SLaM 2014/15	SLaM 2013/14	SLaM 2015/16	National Average 2015/16	Highest Trust % or Score 2015/16	Lowest Trust % Score 2015/16
Number of admissions to acute wards that were gate kept by the CRHT teams	95%	94.1%	91.5%	94.1%	**95.9%**	96.9%	100%	18.3%

Table Five. Access to crisis resolution
The lowest/highest and National Average scores (for a Trust) are based on the Q1-4 scores in 2015/16 published at the time of writing the quality account available at www.england.nhs.uk/statistics

Note that Psychiatric Liaison Nurse assessments of patients in Emergency Departments are, as in previous years, included in the gatekeeping performance figures.

2.11.3 Readmissions to hospital within 28 days of discharge- (Awaiting time lapse and data validation)

*Pending elapse of 28 days from 31/03/15 for full year figure

	SLaM 2013/14	SLaM 2014/15	SLaM 2014/15
Patients readmitted to hospital within 28 days of being discharged			

Table Six. Readmissions to hospital - adult acute patients only

2.11.4. Service Users Experience of Health and Social Care Staff

	SLaM 2014/2015	SLaM 2015/2016	Highest Trust % or Score 14/15	Lowest Trust % or Score 14/15
Service users experience of health and Social Care Staff	8.1	7.6	8.2	6.8

Table seven;. Service Users Experience of Health and Social care Staff

SLaM considers that this data is described for the following reasons:

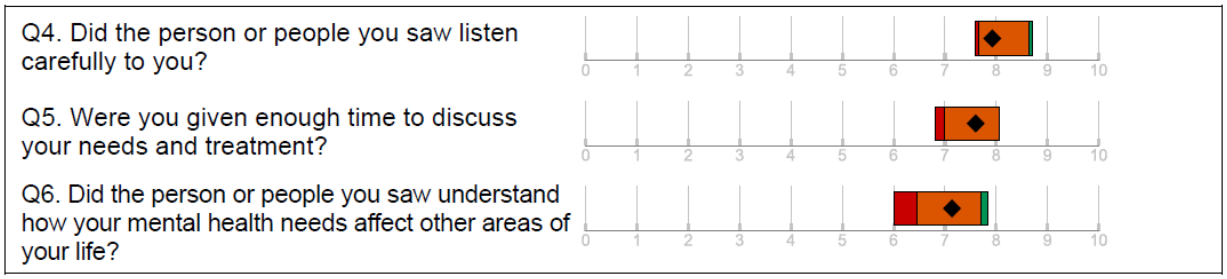
The patient survey responses to the question of how users of services found the health and social care staff of the Trust show that in 2015, overall SLaM scores were slightly higher than the average scores compared to other mental health Trusts. The average Health and Social Care Worker section score for SLaM patients was 7.6 with other Trusts performing in a range of 6.8 to 8.2. This is a decrease from the 2014 SLaM responses which gave an average score for this section of 8.1. However, averages for other Trusts performance also saw a decrease from 2014 where the range was from 7.3 to 8.4.

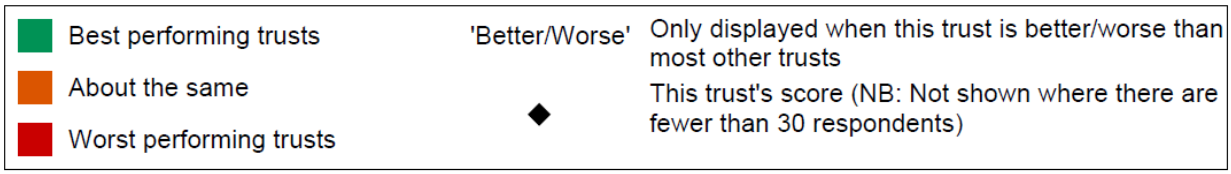
Survey of people who use community mental health services 2015
South London and Maudsley NHS Foundation Trust

		Scores for this NHS trust	Lowest trust score achieved	Highest trust score achieved	Number of respondents (this trust)	2014 scores for this NHS trust	Change from 2014
Health and social care workers							
S1	Section score	7.6	6.8	8.2			
Q4	Did the person or people you saw listen carefully to you?	7.9	7.6	8.7	237	8.5	
Q5	Were you given enough time to discuss your needs and treatment?	7.6	6.8	8.0	236	8.0	
Q6	Did the person or people you saw understand how your mental health needs affect other areas of your life?	7.1	6.0	7.8	227	7.8	

Survey of people who use community mental health services 2015
South London and Maudsley NHS Foundation Trust

Health and social care workers





Our performance against the patient survey questions relating to Health and Social Care workers was in the mid-range and average compared with other mental health trusts.

2.11.5. Monitor Risk Assessment Framework Indicators

SLaM is required to report quarterly to Monitor (the Foundation Trust regulator) against a list of published indicators which link to existing commitments and national priorities within the periodic review 2015/2016.
The indicators are:

Indicator	SLaM Performance 2015/16	National Target
Improving access to psychological therapies (IAPT): people with common mental health conditions referred to the IAPT programme will be treated within 6 weeks of referral (NEW measure introduced late 2015/16)	89.6%	75%
Improving access to psychological therapies (IAPT): people with common mental health conditions referred to the IAPT programme will be treated within 18 weeks of referral (NEW measure introduced late 2015/16)	99.4%	95%
Percentage of patients who had a 12 month care review (patients on the Care Programme Approach - CPA)	95.4%	95%
Meeting commitment to serve new psychosis cases by early intervention teams	100%	95%
Percentage of patients whose transfer of care (from hospital) was delayed	3.9%	<7.5%
Data Completeness, Mental Health: identifiers - NHS Number, Date of Birth, Post Code, Gender, GP code, Commissioner code	99.2%	97%
Data Completeness, Mental Health: outcomes (for patients on CPA) - accommodation and employment status	52.1%	50%

The results for indicators 1, 2, 3, 6, and 7 are Quarter 4 results. HSCIC publish finalised data for indicators 6 and 7 after completion of the Quality Accounts.

2.12. Patient safety incidents resulting in severe harm or death

The Trust records all reported incidents on a database, in order to support the management of, monitoring and learning from all types of untoward incident. In addition patient safety incidents are uploaded to the National Reporting and Learning Service (NRLS) for further monitoring and inter-Trust comparisons. The NRLS system enables patient safety incident reports to be submitted to a national database which is designed to promote understanding and learning.

During 2015/2016 there were 5586 incidents reported by the Trust meeting the NRLS criteria for a patient safety incident. Of these 52 were categorized as 'severe harm' and a further 26 as deaths.

The process of reporting Trust data to the NRLS and NRLS publication of national data is retrospective by nature. The latest available benchmarked data is for period Q1-Q2 2015/16. For this period SLaM reported:

NRLS Data Q1-Q2 14/15	SLAM 14/15	Average for Mental Health Trusts	Highest Trust % or Score 14/15	Lowest Trust % or Score 14/15
Reported Incidents per 1000 bed days	28.06	41.88	83.72	6.46
Percentage of incidents resulting in severe harm	0.9%	0.4%	1.0%	0.1%
Percentage of incidents reported as deaths	0.4%	0.8%	0.6%	0.2%

Table 7. NRLS data on reported incidents

This year the Trust has taken the following actions in trying to improve further its reporting processes in line with external requirements.

- Review its reporting and management of serious incidents in light of the new Serious Incident Framework 2015; published in March 2015.
- Held a Rapid Improvement Event which looked at the Trust Serious Incident processes and the interface with external reporting.
- Continue the implementation of the national patient safety thermometer to encourage staff to report categories of physical health incidents.

- Working closely with the NRLS regarding improved reporting, mapping and the uploading of incidents to ensure real time information is produced.

- To implement with the NRLS the new Dataset 2 which will ensure that interpretation of Trust data within the NRLS database is more accurate and coherent.

- To ensure that multiple staff in the Trust is trained in auditing and uploading NRLS related data and that this does not solely sit with one member of staff.

- The responsibility of finally approving Trust-wide incidents has now been moved from the DatixWeb central team to the CAG/Services as advised by the NRLS and a concerted effort is being made to clear the back log of incidents currently on the system. Once this has been achieved a more robust and fluid method can be implemented within the DatixWeb central team for monitoring and uploading NRLS incidents which will result in improved data quality and performance within the NRLS remit.

- In April 2016 the Severity grading system was amended to fall in line with the NRLS structure which should ensure more accurate translation of future published reports.

2.13 Duty of Candour

In March 2016 further mandatory Datix (Trust Incident reporting system) fields for the recording of Duty of Candour were added to the Trust's Datix system and the completion of these fields is currently undergoing a two week pilot within the BDP CAG. The results of this pilot will be produced at the end of March 2016. The Duty of Candour mandatory fields that have been added to Datix in March 2016 are as follows:

1. Was the patient/appropriate person informed that an incident occurred?

2. When was the patient /appropriate person informed? (dd/MM/yyyy)

3. Please provide details of the patient/appropriate person who was informed.

4. Was the patient/appropriate person advised about next investigative steps to be undertaken?

5. Following a thorough investigation were details related to personnel or system insufficiencies/failures discussed?

6. Was a copy of this detailed report provided in full to the patient/appropriate person?

7. Were support services offered to the patient/appropriate person affected by the incident?

Part 3: Review of quality performance 2015/2016

3.1 Review of progress made against last year's priorities

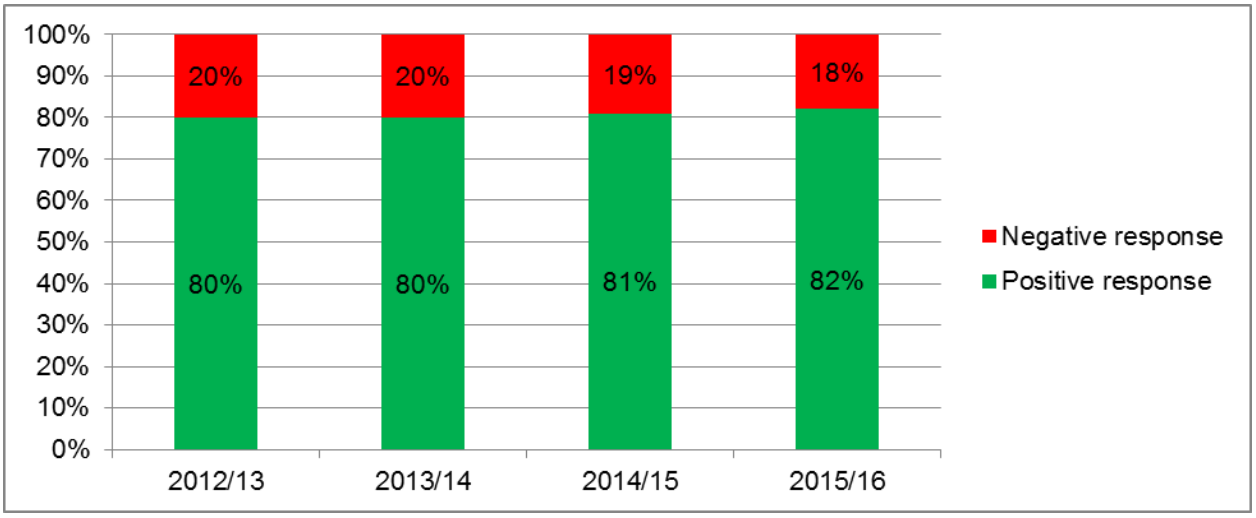
Our 2015/2016 quality priorities were selected after consultations with stakeholders and staff from our services. The following summarises progress made against each priority over the year.

Priority One – Patient Safety: Increase the number of patients who feel safer when in hospital

Violence and aggression on in-patient wards continues to be a challenge in ensuring that all patients benefit from a safe and therapeutic stay in hospital. For 2015/2016 we stated that this was our top clinical Risk, in line with the new National strategy.

Target	We said that in 2015/16 our target was to increase the number of people who when asked say they feel safe in our services. Target >90% of patients feel safe.
Measure	We said we would measure this by asking the question in our patient surveys; "Do you feel safe?"
Headline	**This was nearly achieved.** There were 2560 responses to this question across the inpatient services in 2015/16. 82% of patients responded positively to the question, "Do you feel safe". Whilst there was a very slight increase on the preceding years of 1%, it is below the target of 90%. There was a significant increase from last year in the response rate of 42% and the response once again differed by CAG and borough.

PEDIC Data "Do You Feel Safe"



Graph One

***Positive Response**: Yes, yes, to some extent and yes, definitely

Negative response: No, Definitely not, Not really, Don't know

This priority has been rolled over next year as part of the Trust violence reduction strategy.

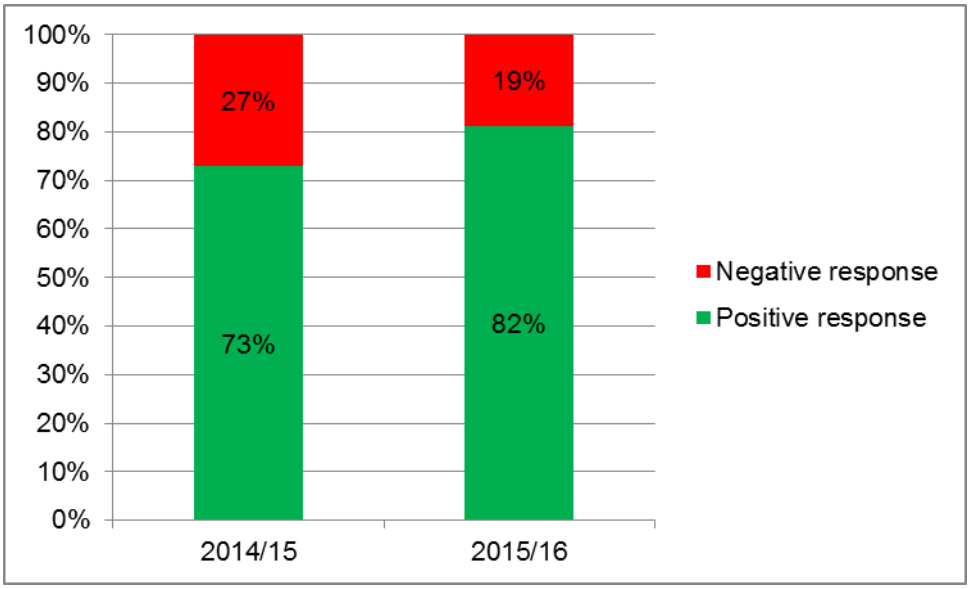
Priority Two – Patient Safety: Access to help in a Crisis

This priority was identified as a recurrent theme during the consultation process from patients, carers and other stakeholders. This had also been raised as an issue by patients in the National survey. In 2014/2015 we said **we would make it easier for patients to access help in a crisis.**

Target	At least 75% of all community patients asked will respond positively to this survey question 'Do you know what to do in an emergency mental health situation?'.
Measure	We will measure this by asking patients about their experience, in the form of surveys.
Headline	**We achieved this.** There were 4489 responses to this question in 2015/16. 82% of community patients responded positively to the question "Do you know what to do in a mental health emergency". This is an improvement of 9% since 2014/15

As outlined earlier in this report the 24/7 Crisis line which is operated 24/7 by mental health professionals was launched in December 2015. This service was advertised on both the SLaM website as well as the South London press newspaper. There is continuing work in developing further publicity and information leaflets to promote this service further.

PEDIC Data "Do you know what to do in a mental health emergency?"



Priority Three – Clinical Effectiveness: Physical healthcare screening

This target recognises the importance in improving our screening of patients for cardio-vascular and metabolic disease. This is a continuation of the CQUIN work during the last two years.

Target	90% of patients audited during the period (inpatients)or for 80% of (community EIP), patients audited during the period the Trust has undertaken an assessment of each of the following key cardio metabolic parameters with a record of associated interventions.
Measure	This was measured through a process similar to the 14/15 National Audit of Schizophrenia, on cardio metabolic risk factors in patients with schizophrenia. • Smoking status; • Lifestyle (including exercise, diet alcohol and drugs); • Body Mass Index; • Blood pressure; • Glucose regulation

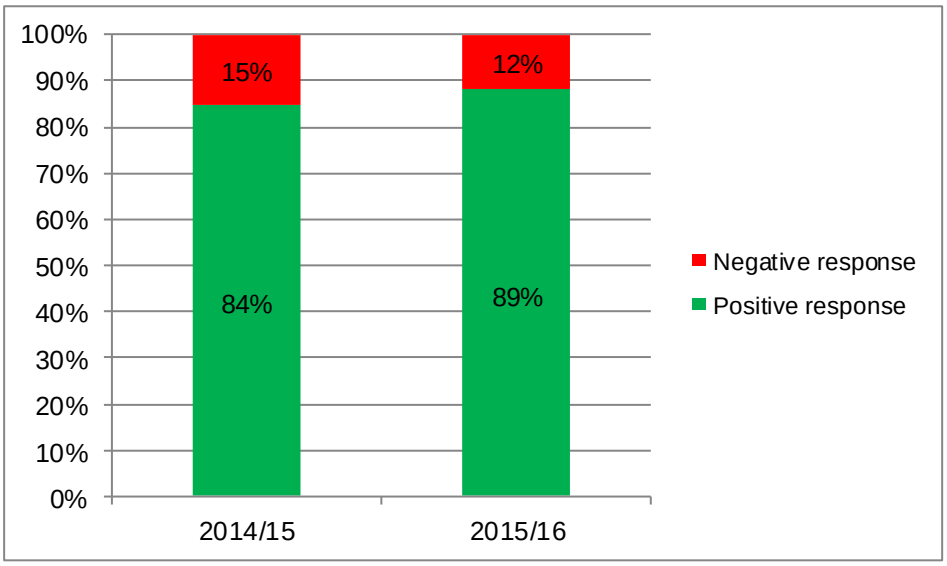
	• Blood lipids.
Headline	**We partially achieved this** The audit sample taken From July/September Q2 patients achieved 85.43%. The audit results taken from Q4 Jan/March for the CQUIN submission and allowing for further quality improvement work throughout the year had shown further improvement with an overall score for Inpatients 91% and for Community EIP 68%.

In response to these findings, the 2015/16 PH CQUIN also emphasised staff training and a widespread physical training programme was provided to nurses and support workers Now most sector wards offer health groups that often include a combination of health education and physical group exercise.

Priority Four – Patient experience; Care planning

In 2015/2016 we aimed to ensure patients identify and achieve outcomes that matter to them, and that users are at the centre of their own care. We wanted to ensure patients are involved in their care and ensure patients understand their care plans in both in-patient and community settings.

Target	Our target is to increase the number >83.5% of people who when asked will say they feel involved in their care.
Measure	We will measure this by asking the questions in our patient surveys; **'Do you feel involved in your care'?**
Headline	**We achieved this.** There were 8299 responses to this question in 2015/16. 89% of people asked responded positively when asked the question "Do you feel involved in your care?". This is an improvement of 5% since 2014/15.



PEDIC Data

"Do you feel involved in your care?"

This year has seen a lot of work involved in improving patient involvement with their care plans and ensuring they are personalised which included an audit on current practice and a workshop which looking at the deficits highlighted from the Care Plan Audit. There was a subsequent Care Planning Workshop to identify actions and take matters forward which will include formulating guidance for staff including updating staff of the tools available on EPJS.

Priority Five – Patient Experience: Carers Assessments

The role of the carer had been raised by carers and services in feedback such as complaints and serious incidents. Where there is an identified carer, they should be offered a carer's assessment. Over the course of five years as part of our five year strategy we would hope to build on the target below further.

Target	Our target is 30% of identified carers will have been offered a carer's assessment.
Measure	Trust Audit Random sample of 100 patients on CPA
Headline	**We achieved this.** The audit showed that 32% of the identified carers were offered a carers assessment. This is an improvement of only 2% since the 2014/15 audit. The methodology changed slightly this year to widen the scope/sample on who an 'identified carer' could be which could have affected the results. Nethertheless, the limited improvement of this Priority has resulted in this priority being rolled over to 2016/17.

There was limited improvement this year due to delay in fully implementing of the Care Act in a consistent way across all four boroughs. Workshops have since been held to agree action to address this which has included interim guidance to staff. This priority has been rolled over to the next year to further improve in this area.

Priority Six – patient Experience; Environments

We said that we would further improve quality of the environments within our In-patient wards and build on the work carried out in 2014/2015.

Target	Improvement in environmental PLACE audit scores from 2014/2015 >95%.
Measure	PLACE (Patient Led Assessment of the Care Environment) audit scores.
Headline	**We achieved this.** The environmental PLACE scores improved this year and both were above the national average.

The following table shows the PLACE scores for the previous three years.

Year	Site	Cleanliness	Condition Appearance and Maintenance
2013	All sites	81.89%	81.28%
2014	All Sites	92.15%	96.22%
2015	All Sites	99.61%	97.68%
2014	% Improvements	10.26%	14.95%
2015	% Improvements	7.46%	1.45%
2014	National Average	97.25%	91.97%
2015	National Average	97.57%	90.11%
2015	% above National Average	2.04%	7.57%

Priority Seven – Patient Safety; Risk Assessments

Based on serious incidents feedback we aimed to improve '**how full risk assessments for Inpatients and Community patients on CPA are documented and used to inform decisions on patient care**'

Target	75% of Inpatients and Community Patients on CPA will have a full documented risk assessment.
Measure	Trust Audit
Headline	**We achieved this.** The audit showed 78% of inpatients and community patients on the CPA had a full risk assessment documented.

Priority Eight – Clinical Effectiveness- Home Treatment Teams support

We said the Adult Mental Health (AMH) model provides an enhanced multi-intervention service into the community. Home treatment teams (HTT) provide intensive support for people in mental health crisis in their own home. We said we aimed ' **this year we will reduce the number of people supported by HTT who then require an admission.'**

Target	No more than 15% of people who have been supported by HTT to then require an Inpatient admission in services where the AMH model has been established.
Measure	We said we would measure this by extracting data on patient admissions from our electronic records system in Q4/2016.
Headline	**We achieved this.** In the HTT services where the AMH model has been established, 9% of HTT episodes resulted in an admission.

TOTAL	2015/16	2015/16	2015/16	Q4	Total	%
	Q4					
	Jan	Feb	Mar			
New episodes receiving Home Treatment	95	106	117	**318**	**318**	
Not Admitted During HTT Episode	85	97	106	**288**	**288**	
Admitted During HTT Episode	10	9	11	**30**	**30**	**9%**

A key aim of the AMH model has been for HTTs to develop close interface working with community teams to intervene early and reduce the need for crisis admissions. There has been a recent focus on strengthening working relationships with acute in-patient teams. HTT linking working roles have been developed to meet regularly with in-patient staff and attend ward meetings with the aim of facilitating timely in-patient discharges from hospital and reducing length of stay.

Dialectical behavior therapy (DBT) awareness training for mental practitioners has been rolled out across the HTTs to support the use of DBT informed interventions. As well as providing a basic understanding of DBT the training has equipped staff with a range of interventions to support service users in developing distress tolerance / management skills.

Priority Nine – Clinical Effectiveness: Substance Misuse

Co-morbid substance use is very common in people with mental health problems (30-50% and in some groups even higher), so working with people with dual disorders is core to modern mental health care. **We will increase the frequency with which people in SLaM services are asked about their use of alcohol and non-prescribed drugs so that we can work more effectively with them to maintain their safety and plan recovery.**

Target	50% of service users from our adult acute Inpatient and Adult Community teams will have both a drug and alcohol assessment and an AUDIT (Alcohol Use Disorders Identification Test) completed.
Measure	Trust Audit
Headline	**We achieved this partially** There was an improvement in adult acute inpatient services where 67% of service users had a drug and alcohol assessment. However the Trust did not achieve the targets for community service users. It has been agreed that this will be CQUIN target next year.

3.2 National patient survey of people who use community mental health services: SLaM report 2015

The national patient survey was returned by 246 SLaM patients giving a response rate of 30% which is just above the national average for all mental health trusts of 29%

Overall, SLaM's results fell in the amber section in 10 out of the 10 sections of the survey meaning, our results were 'about the same' as most other trusts. In the final 'Overall' Section, SLaM performed 'about the same as other trusts. In the graphics below the Trust score is represented by a small diamond. If the score is placed in the amber section of the Red, Amber, Green (RAG) rating then that result is considered 'about the same' as most other trusts. If the score is in the red section of the RAG, the result is considered 'worse' than most other trusts and likewise if the score is in the green section, the result is considered 'better' than most other trusts.

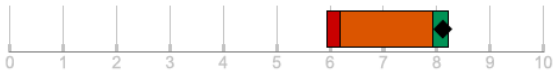
Out of the 41 individual questions in the survey, the top ranking scores for SLaM compared to other mental health trusts in England was found for the following 3 questions:

Section 2: Organising Your Care

Q9. Do you know how to contact this person if you have a concern about your care?

Section 5: Changes in Who You See

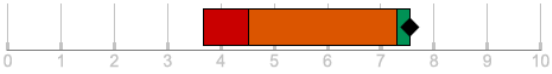
Q18. What impact has this had on the care you receive?



Better

Section 6: Crisis Care

Q22. When you tried to contact them, did you get the help you needed?



Better

For no questions in the 2015 Survey of people who use community mental health services did SLaM perform among the worst performing trusts.

Improvement Plans

The Trust is looking to improve on a range of patient experience areas throughout 2016/17 all of which are closely related to the National Community Survey, the Friends & Family Test (FFT), our internal patient experience surveys and are inclusive of other areas that are equally important to service users, carers and staff.

The number of responses for the FFT and the patient experience surveys has increased from the previous year. For 2015/16, the Trust received over 8500 survey and FFT responses, approximately over 1000 more responses. The overall FFT score for the Trust was 84.3%, comparing very favourably against other mental health trust. The FFT score suggests that patients and carers would recommend their friends or family to use our services. The Trust is also one of only a small number of NHS organisations to provide demographic breakdowns of the experiences of patients. This is published as part of the Trust's annual Equality Information to show the experience of patients with different protected characteristics has changed over time.

In terms of the internal survey questions highlighted below, they will remain as the same patient experience priorities for all of services

1. Do you feel involved in your care?
2. Are staff kind and caring?
3. Do you know how to make a complaint?
4. Do you know what to do in an emergency mental health crisis?
5. Do we treat you as an individual by considering your culture, spirituality, disability, gender, sexuality, age and ethnicity?
6. Do you feel safe here?
7. Has the purpose and side effects of your medication been explained to you?

The Trust will further undertake a benchmarking exercise against a number of the survey questions above. This will provide an in-depth understanding, and help the Trust to direct resources more appropriately. Each CAG will be expected to provide series of action plans, against underperforming areas the action plans will be reassessed for progress, followed by implementation and expected improvements.

3.3 National Staff Survey 2015 – Results

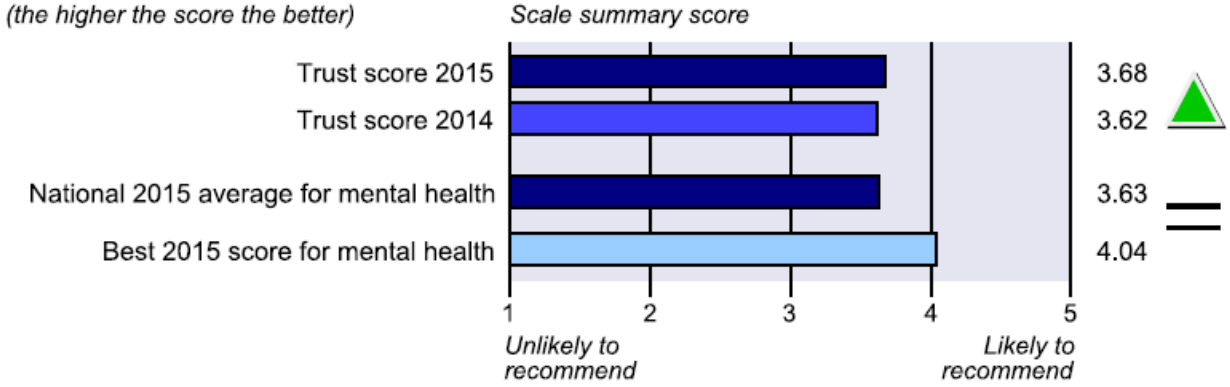
1699 staff at South London and Maudsley NHS Foundation Trust took part in this survey. This is a response rate of 38%1 which is below average for mental health / learning disability trusts in England, and compares with a response rate of 42% in this trust in the 2014 survey.

Number of Staff recommending the Trust

In the 2015 staff survey, SLaM performed slightly better than the year before on the question 'would staff recommend the trust as a place to work or receive treatment?'. SLaM performed slightly above the national average on this question. The SLaM Trust score for this question was 3.68 compared to the national average score of 3.63 for other mental health trusts.

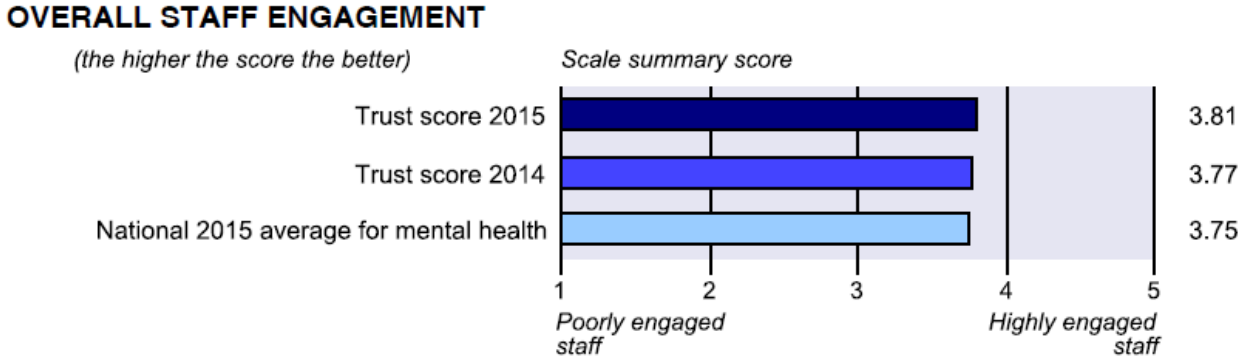
		Your Trust in 2015	Average (median) for mental health	Your Trust in 2014
Q21c	"I would recommend my organisation as a place to work"	59%	56%	59%
Q21d	"If a friend or relative needed treatment, I would be happy with the standard of care provided by this organisation"	60%	59%	58%
KF1.	Staff recommendation of the organisation as a place to work or receive treatment (Q21a, 21c-d)	3.68	3.66	3.61

KEY FINDING 1. Staff recommendation of the organisation as a place to work or receive treatment



Overall Staff Engagement

The Trust score for overall staff engagement has gone up to **3.81** (3.76 in 2014). This is higher than the national average for all mental health/learning disability Trusts which was 3.75.



Key Findings – overall Trust

<u>The following are the top five ranking scores for the Trust compared to Mental Health Trusts in England:</u>

- Percentage of staff appraised in last 12 months.
  Trust Score: 96% **National Average: 89%**

- Effective team working (scale summary score).
  Trust Score: 3.90 **National Average: 3.82**

- Percentage of staff able to contribute towards improvements at work.
  Trust Score: 76% **National Average: 73%**

- Quality of non-mandatory training, learning or development (scale summary score).
  Trust Score: 4.10 **National Average: 4.01**

- Effective use of patient / service user feedback (scale summary score).
  Trust Score: 3.81 **National Average: 3.68**

<u>The following are the lowest five ranking scores for the Trust compared to Mental Trusts in England:</u>

- Percentage of staff working extra hours
  Trust Score: 81% **National Average: 74%**

- Percentage of staff experiencing physical violence from staff in last 12 months
  Trust Score: 5% **National Average: 3%**

- Percentage of staff believing that the organisation provides equal opportunities for career progression or promotion
  Trust Score: 77% National Average: 84%

- Percentage of staff experiencing harassment, bullying or abuse from patients, relatives or the public in last 12 months.
  Trust Score: 36% National Average: 32%

- Percentage of staff experiencing discrimination at work in last 12 months
  Trust Score: 20% National Average: 14%

<u>The following is the area where the experience of staff has improved on the previous annual survey:</u>

- Percentage of staff appraised in last 12 months.
  Trust Score 2015: 96% Trust Score 2014: 87%

- Percentage of staff witnessing potentially harmful errors, near misses or incidents in last month
  Trust Score 2015: 27% Trust Score 2014: 32%

- Staff recommendation of the organisation as a place to work or receive treatment (scale summary score).
  Trust Score 2015: 3.68 Trust Score 2014: 3.62

<u>The following is the area where the experience of staff has deteriorated most on the previous annual survey:</u>

Percentage of staff working extra hours.
Trust Score 2014: 81% Trust Score 2013: 77%

At a Trust wide level, there are themes that have been identified in the lowest five ranking areas that are of concern and work needs to be undertaken to address these.

The report reminds us that SLaM is in the worst 20% in terms of the percentage of staff who experience physical violence (from other staff), the percentage of staff who receive harassment, bullying or abuse from patients and those who experience discrimination. All of which are reported as being worse for BME staff.

At a local level, each CAG and Directorate will be asked to develop an Action Plan in relation to the responses in the staff survey. This should be based on the requirements

identified within the report for their specific areas as some CAGs may need to develop and improve approaches to particular themes. There will need to be regular updates on progress through the CAG HR Business Partners. It is important that local issues are identified and staff are given the opportunity to work towards their resolution and for the CAGs to reassure their staff that they have heard the feedback and are addressing it.

We need to ensure we maintain our areas where we have scored in the top 20% of mental health and learning disability Trusts.

We will continue to engage with the Nursing Directorate to develop and improve upon our approaches to the management of violence and aggression as experienced by our staff whilst at work as Nurses and Healthcare Support workers report this the highest. We will ask the Nursing Directorate if further audits of violence and aggression can be undertaken especially in the B&D, Psychological Medicine and Psychosis CAGs where this is reported the highest.

We will need to continue to reinforce the importance of the new annual performance review (appraisal) process which commenced in 2015. We have updated the ratings guide and redesigned the recording form. The performance review process allows an open dialogue about what is good and what needs to improve.

We will continue work to support the development of the BME Network and develop activities, priorities and terms of reference including formal nominations for the Chair and vice Chair roles.

We will need to conduct further analysis for the reasons why staff are working and reporting working extra hours. We will start this analysis in B&D and CAMHS. We will also undertake a review of our approach and policy for flexible working arrangements within the Trust.

We will follow up on the areas where staff have reported suffering from workplace stress and ascertain whether Individual workplace risk assessments have been conducted plus compare sickness absence rates for this reason.

HR Business Partners will work with their respective CAGs and Directorates to identify if there are areas where reports of bullying, harassment, abuse or violence from staff to other staff are not being followed up.

We recognise that we will not have an easy fix to some of the work that needs to be done but equally we know that we all have a part to play in making SLaM a better place to work.

3.4 SLaM Equality Objectives 2013-16

During 2015-16 the trust has continued to deliver its equality objectives:

1. All SLaM service users have a say in their care

2. SLaM staff treat all service users and carers well and help them achieve the goals they set for their recovery

3. All service users feel safe in SLaM services

4. To improve the representation of BME staff and staff with a disability in all aspects of meaningful engagement, participation and inclusion within the Trust

5. Show leadership on equality through our communication and behaviour

The Trust's Policy Working Group has helped support policy leads to use equality impact assessments (EIAs) in the development and review of Trust policies. This has helped increase the quantity and quality of EIAs and identified actions and helped improve the Trust's understanding of how policies affect service users with different protected characteristics and what the Trust can do about this.

Ensuring all service users feel safe and involved in their care in SLaM services are two of the Trust's equality objectives 2013-16. We have published information on the feelings of safety reported by service users with different protected characteristics and examples of work underway to ensure all service users feel safe as part of our annual equality information. This is available on our website at: **2015 Trust-wide equality information.**

We published an update on our equality objective delivery in January 2016. This is available on our website at: **A report on our progress on equality in 2015**. We will continue to deliver our equality objectives and will engage with service users, carers, staff and other stakeholders during 2016 to assess the impact these have had and develop new equality objectives for 2017-20.