South London and Maudsley NHS
NHS Foundation Trust

DRAFT Quality Account for 2016/2017

(To be formatted professionally for publication)

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Part 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.

The National Health Service (NHS) is facing unprecedented financial pressures; these pressures are experienced in our Trust and we have worked hard to ensure the quality of care has not been compromised.

This year has been an important year in improving the quality of the service we provide to both our patients and carers. We have made a really good start to our Quality Improvement (QI) work. Many staff have already attended training, and a raft of QI initiatives are now in train across the Trust. It is core to our strategy to deliver long term sustainability through our pursuit of quality and value. Most importantly we are continuing to deliver high quality care to all of the people who use our services. One way in which this is reflected is through external recognition – for example the individuals and teams who were winners in five categories at the recent Royal College of Psychiatrists awards.

Working in close partnership with the people who make use of our services, their friends, families, carers and local communities is key to our ability to support people in achieving the best possible health outcomes. For QI to work within our trust, it is also key that these partnerships run through our improvement projects at all levels of the organisation. It is with this in mind, we will be opening up our QI training to those who use our services along with their friends, families and carers.

We recognise that valuing staff is an important feature in providing high quality care and in 2016 we held our first Trustwide staff awards, which was a successful day in recognising the contributions staff make in delivering quality care. We are also proud that the national staff survey showed that the Trust scored above the national average for staff recommending the organisation as a place to work. It is recognised that engaged staff who feel supported and empowered at work provide the best quality care therefore building on our success in this area will remain a priority.

The Care Quality Commission (CQC) carried out week long focussed inspections of both our Acute and Mental Health Older Adults (MHOA) pathways to ensure implementation of the actions plans following the 2015 inspection. At this point we have only received the formal written feedback to the Acute re-inspection, which I am pleased has resulted in the Trust no longer having any services that are rated 'inadequate' in any of the five domains and has highlighted positive improvements delivered by our staff since our 2015 inspection. We are awaiting the final report for our MHOA services but initial verbal feedback has again been positive in highlighting improvements made. We remain committed to keep improving the quality of services, our top priority in the year ahead.

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

A summary of successes and developments in 2016/2017

AREA	SUCCESS/DEVELOPMENTS
Care Quality Commission (CQC)	➢ Sustained the overall Inspection rating of 'Good' given in 2015. ➢ Acute and MHOA compliance inspections demonstrated improvements as a result of action plans.
ICT/Technology	➢ SLaM's Chief Information Officer (CIO) was ranked 55th in the UK top 100 Chief Information Officers
Research	➢ The Pioneering research registration scheme has had over 10,000 patients agree to be contacted to participate in research, following the "*Consent for Contact*" (C4C) programme. ➢ SLaM was rated the top mental health trust in the country for recruiting patients to clinical studies, in October 2016, by the National Institute for Health Research (NIHR) and Clinical Research Network (CRN).
Awards/Creditations	➢ In September 2016, the Director of the NIHR Maudsley Biomedical Research Centre won the prestigious "*Katon Research Award*" from the Academy of Psychosomatic Medicine. ➢ In October 2016, Forensic inpatient services won six awards in the Koestler Trust Awards. The awards were for art work done by service users from River House. ➢ The Psychological Interventions Clinic for Outpatients with Psychosis (PiCup) Clinic is shortlisted for the 2017 HSJ Value in Healthcare Awards. The awards are for NHS services that responded to the NHS' drive to improve the cost effectiveness of its care. The service is nominated for two awards. ➢ Seven researchers received prestigious "Senior Investigator Awards" from NIHR research wing of NHS. ➢ Organisers of the Schwartz Round won an award for the Best Academic Poster at Points of Care Foundation's annual Schwartz Community Conference. ➢ In June 2016, the ward manager of Acorn Lodge Inpatient children's unit was shortlisted for Nurse of the Year in the prestigious Nursing Times Awards.

	➢ A SLaM pharmacist won UKCPA Patient Safety Award for their pilot scheme. It was for work in pharmaceutical care of patients on "*psychotropic*" medication in an acute hospital. ➢ Local Care Record won an award at eHealth Insider (EHI) Award held in September 2016. The category was "*Best use of IT to support integrated health care services*". The service joins up patient records between GP practices in Lambeth and Southwark with Guy's & St Thomas', Kings College Hospital (KCH) and SLaM. ➢ The National Adult Outpatient Neurodevelopmental Clinic won the "*Outstanding Health Services*" award at the Autism Professionals Awards held in March 2017 (National Autistic Society's).
External Organisations	➢ Public Health England (PHE) are working to promote NHS being tobacco free and they have encouraged NHS to follow SLaM, as SLaM is one of the first mental health trusts to be smoke free
24 hour crisis Line	➢ The SLaM 24 hour crisis helpline was one of the top ten most read stories in the "Mental Health Today" (MHT). The MHT is a guide to understanding and achieving the best in mental healthcare.
Other	➢ The Bethlem Hospital's new Gallery and Museum space in the original hospital administration building was shortlisted down to the last 4 for the national museum of the year award.

Table one: A summary of successes and developments in 2016/2017

…..and what we can do better.

- **We need to improve in the areas that the CQC inspectors judged to require further improvement in their last two visits, whilst the Trust is awaiting the final version report the areas raised verbally included;**
- **Improve staff levels and vacancies, a reduction in prone restraint, individualised care planning.**

All these have been translated into quality priorities for 2017/18.

Trust Activity

During 2016/2017 the Trust provided or subcontracted 255 services including inpatient wards, outpatient and community services. As well as serving the communities of south London, we provide 53 specialist services for children and adults across the UK including perinatal services, eating disorders, psychosis and autism. We provide inpatient care for approximately 3,900

people each year and we treat more than 67,000 patients in the community in Lambeth, Southwark, Lewisham and Croydon, with a local population of 1.3 million with a rich diversity.

South London and Maudsley NHS Foundation Trust (SLaM) has reviewed all the data available to us on the quality of care in these relevant health services.

The income generated by the relevant health services reviewed in 2016/17 represents 100% of the total income generated from the provision of relevant health services by SLaM for 2016/17

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

Our priorities for improvement for 2017/2018

Over the last year we have listened to feedback from service users, their families, carers, staff, local Healthwatches, Council of Governors as well as commissioners and regulators. A Trust Quality priority setting event was held on the 22nd February 2017 with all our stakeholders. This feedback alongside feedback from CQC focused visits in January and March 2017 as well as Trust information from complaints, serious incidents and audits has helped us to identify our future priorities.

The Trust is committed to being a learning organisation and will continue the work underway to ensure outcomes from incidents, CQC Mental Health Act (MHA) inspections, complaints will all be used to improve the care we deliver.

Quality Improvement

Over the last year the Trust has seen a drive to improve the quality of care we provide and the implementation of the Trust Improvement strategy by using Quality Improvement methodology. The Trust has made a really good start to our Quality Improvement work with many staff now trained in QI methodology. It is this pursuit of quality and value that will deliver longer term sustainability.

Mission Statement

Our long term vision is to create and sustain a culture of continuous quality improvement

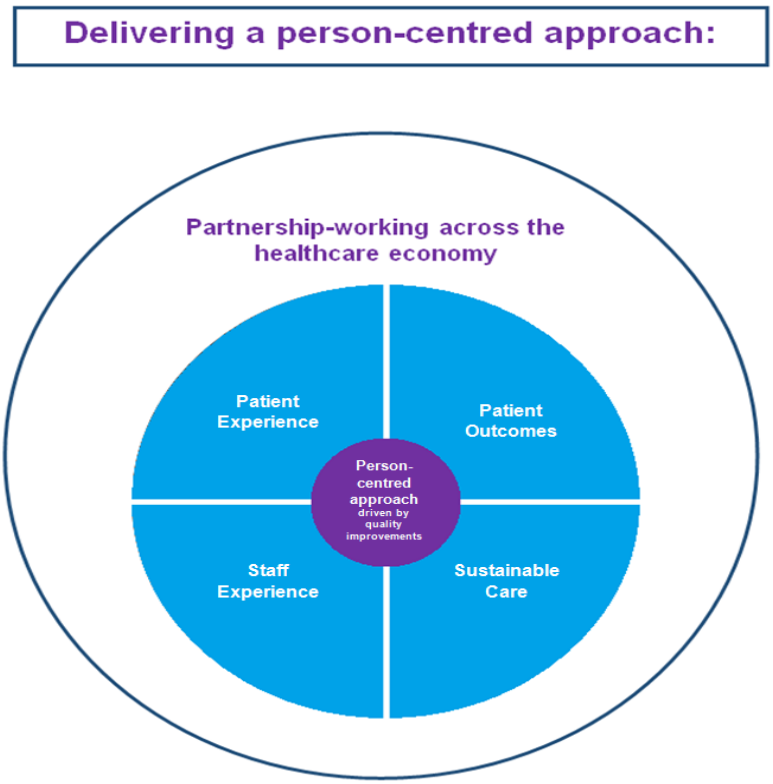
How we plan to do it

We aim to become an organisation with a culture of continuous improvement that is based on service users, carers, staff and key partners working together. We want to improve **outcomes** and experiences for all people who use our services, and improve the **value** of the care we provide.

This is a bottom up approach, not top down. The programme will support staff to learn and use quality improvement methods, involving and engaging **everyone** in thinking about how to improve services.

Trust Improvement Plan

The aim of the Trust improvement plan is to deliver the Right Care in the Right Place at the Right Time with the Right Value. This will be achieved through delivering a person centred approach, improving safety, experience, outcomes and delivering balanced budgets within agreed time frames. The strategy is outlined in the graph below.



Graph one: Trust Improvement plan

The quality indicators below align to both the Trust Improvement plan outlined above and the nationally set areas of patient safety, clinical effectiveness and patient experience.

Quality Priorities 2017/2018

The priorities for 2017/2018 have been arranged under three broad domains 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	**1.Reducing Restrictive Interventions**	
	Aim	Reducing Violence
	Quality Indicator	Reducing restrictive interventions; prone restraint, Inpatient areas Reduction of 50% in prone restraint Baseline: year 16/17 874
	How progress will be monitored	Quality Service Committee (QSC), Board, Performance monitoring reports, Safe and Therapeutic Services Committee (STSC)

Patient Safety	2.Violence & Aggression Reduction	
	Aim	Reducing Violence
	Quality Indicator	Violence and aggression reduction of 50% Baseline: Year 16/17, Inpatient areas 1819
	How progress will be monitored	QSC, Board, Performance monitoring reports, STSC

Patient Safety	3. Staffing	
	Aim	Staffing Levels
	Quality Indicator	>50% wards reduction of average inpatient ward breaches per month Baseline: 20 wards
	How progress will be monitored	QSC, Board, Performance monitoring reports

Clinical Effectiveness	4. Digital Health	
	Aim	A reduction in mortality of people with severe mental health problems
	Quality Indicator	Further develop electronic systems to improve delivery of care (eOBS) across all Trust service areas. >50% of all Adult inpatient wards Baseline: 2 wards
	How progress will be monitored	QSC, Board, Performance monitoring reports, Quality Dashboard, Physical healthcare project Board

Clinical Effectiveness	5. Physical Health Awareness	
	Aim	A reduction in mortality of people with severe mental health problems
	Quality Indicator	Ensure clinical and non-clinical staff have received level 1 physical health awareness training across all Trust service areas. Target 65% Baseline 0%
	How progress will be monitored	QSC, Board, Performance monitoring reports, Quality Dashboard, Physical healthcare Committee LEAP Education and training

Clinical Effectiveness	6. Physical Health Screening and Intervention	
	Aim	A reduction in mortality of people with severe mental health problems
	Quality Indicator	Inpatients and early intervention patients will have 90% or greater rates for each metabolic screening parameter and where indicated, interventions. Patients with psychotic illnesses in longer term follow up (CPA) will have 65% or greater for screening / intervention rates. Inpatient and EI Target 90% Community CPA Target 65% Baselines Inpatients: 77% metabolic screening, 60% intervention Early Intervention Services: 52% metabolic screening, 61% intervention Community CPA: 41% metabolic screening, 51% intervention
	How progress will be monitored	QSC, Board, Performance monitoring reports, Quality Dashboard, Physical healthcare Committee LEAP Education and training

Patient Experience	7. Family and Carer Engagement	
	Aim	Ensure Family and Carer Engagement
	Quality Indicator	75% of identified carers in all Trust service areas will have been offered a Carers Engagement and Support Plan. Baseline: 0 (new form)
	How progress will be monitored	QSC, Board, Performance monitoring reports, Quality Dashboard, Carer and Family strategy meeting

Patient Experience	8. Care Closer to Home- Inpatient Admissions	
	Aim	Reduction in overall admissions because patients are better managed in their illnesses at home as is appropriate
	Quality Indicator	10% reduction in admissions in Trust Inpatient Adult Services. Reduction in admissions from 8 to 7 per day
	How progress will be monitored	QSC, Board, Performance monitoring reports, Quality Dashboard

Patient Experience	9. Care closer to home- Length of Stay	
	Aim	Reduction in overall admissions because patients are better managed in their illnesses at home as is appropriate
	Quality Indicator	30% reduction in Length of stay (LOS) in Trust Inpatient Adult services. Reduction in LOS from 45 days to 30 days
	How progress will be monitored	QSC, Board, Performance monitoring reports, Quality Dashboard

Staff Experience	10. Staff Health and Well-Being	
	Aim	To improve structures and processes that facilitate positive staff experience.
	Quality Indicator	Increase of 5 % of staff reporting the organisation **definitely** takes positive action on health and well-being. (CQUIN) Baseline: 25% in 2015 staff survey
	How progress will be monitored	QSC, Board, Performance monitoring reports, Quality Dashboard (Friends and Family Test quarterly) Staff survey

Staff Experience	11. Management of Work Related Stress	
	Aim	To improve structures and processes that facilitate positive staff experience.
	Quality Indicator	Decrease of 5% of staff saying they have felt unwell in the last 12 months as a result of work related stress (CQUIN) Baseline: 43% 2015 staff survey
	How progress will be monitored	QSC, Board, Performance monitoring reports, Quality Dashboard (Friends and Family Test quarterly) Staff survey

Staff Experience	12. Staff recommendation of the organisation as a place to work	
	Aim	To improve structures and processes that facilitate positive staff experience.
	Quality Indicator	Achieve >70% on average across the year of staff reporting they would recommend the organisation as a place to work. Baseline: 63% in 2016/17
	How progress will be monitored	QSC, Board, Performance monitoring reports, Quality Dashboard (Friends and Family Test quarterly) Staff survey

Table two: Quality Priorities 2017/2018

Care Quality Commission (CQC); Inspection September 2017 Results and Actions

SLaM is required to be registered with the CQC and its current registration status is registered, without condition. In 2016/2017 SLaM has participated in special reviews or investigations by the Care Quality Commission relating to the following areas; MHOA and Acute pathway. SLaM is currently awaiting the final report and findings from MHOA which may result in a change in the grid below, which is the current overall and service specific ratings following the results of the comprehensive inspection of some of our services by the CQC in 2015 and Acute in 2017.

SLaM made the following progress by 31st March 2017 in taking such action outlined in table 4. The CQC has not taken enforcement action against SLaM during the period 2016/17.

	Safe	Effective	Caring	Responsive	Well led	Overall
Long stay/rehabilitation mental health wards for working age adults	Requires improvement	Good	Good	Good	Good	Good
Wards for older people with mental health problems	Requires improvement	Requires improvement	Requires improvement	Requires improvement	Good	Requires improvement
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
Child and adolescent mental health wards	Good	Good	Good	Good	Good	Good
Acute wards for adults of working age and psychiatric intensive care units	Requires improvement	Requires improvement	Good	Good	Requires improvement	Requires improvement
Wards for people with learning disabilities or autism	Good	Outstanding ☆	Outstanding ☆	Good	Outstanding ☆	Outstanding ☆
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
Community-based mental health services for older people	Requires improvement	Good	Good	Good	Good	Good
Community-based mental health services for adults of working age	Requires improvement	Good	Good	Good	Good	Good

Table three: Care Quality Commission Inspection Results

The table below outlines some of the quality improvement work currently being undertaken as a result of the CQC live action plans from both 2015 and 2017 inspections.

Area of Improvement	Actions undertaken
Staffing	• E- rostering redesign • Assessment days reviewed and changed. • Media and recruitment campaigns • Development of Band 4 Assistant practitioner role job • Staff retention initiatives implemented.
Food	• New menu introduced • Implemented interactive meal times • New catering contract • Forensic wards – Activity of daily living kitchen
Reducing Restraint	• The Trust has developed a reducing restrictive interventions three year strategy • The strategy provides a framework for the reduction of restrictive interventions across all in-patient services in line with the DH Positive and Safe initiative (2014) • Continued roll out of violence reduction programme called 'Four Steps to Safety'
Environment	Above national average in PLACE scores in: • Cleanliness • Condition, appearance and maintenance • Privacy, dignity and wellbeing
Privacy and Dignity	• Vistamatic windows programme • Variety of daily activities and individual goal setting.
Creating and sustaining a culture of continuous Improvement	Since the CQC inspection in 2015 we have appointed the Institute of Healthcare Improvement and an internal Quality Improvement Team to support us all in our drive to improve the quality of everything we do, with transformation projects now taking place at a local ward and team level.

Table four: CQC Actions

Managing Clinical Risk

Managing clinical risk is central to all the work that we do, to manage risk all clinical staff receive clinical risk management training commensurate with their grade and experience.

Audit

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.

The National Clinical Audits and National Confidential Inquires that SLaM participated in, and for which data collection was completed during 2016/2017, are listed below. During that period SLaM participated in 100% of national clinical audits 6/6 and 100% of National Confidential Inquiries 1/1 which it was eligible to participate in.

The National Clinical Audits and National Confidential Inquiries that SLaM participated in, and was eligible to participate in during 2016/17 are listed below:

- The 5 national, Prescribing Observatory for Mental Health - POMH-UK audits:
  - Use of sodium valproate
  - Prescribing for substance misuse: alcohol detoxification
  - Prescribing antipsychotic medication for people with dementia
  - Monitoring of patients prescribed lithium
  - Rapid tranquilisation
- The Commissioning for Quality and Innovation (CQUIN) 2016/17 Indicator 4a: Improving Physical Healthcare to Reduce Premature Mortality in People with Severe Mental Illness (SMI)
- The national confidential inquiry into suicide and homicide by people with mental illness

The reports of six national clinical audits were reviewed by the provider in 2016/2017 and SLaM intends to take the following actions to improve the quality of healthcare provided

POMH-UK audits

Participation in the five 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 2016-17 POMH-UK audits, as required.

Below is a summary of the findings from those audits:

i) Use of sodium valproate

The National Institute for Health and Care Excellence (NICE) recommends that valproate should not routinely be prescribed for women of childbearing age. In addition to this, all patients prescribed valproate should have an annual physical health check. In 2015, the Trust participated in the national POMH-UK audit of valproate prescribing for bipolar disorder. Results of the audit were reported by POMH in March 2016.

Overall, the rate of prescription of valproate for women of childbearing age was found to be higher in SLaM than in the average national sample (33% vs 8%). Physical health monitoring was evident for more patients prescribed valproate in SLaM than the national average.

Actions: The Trust is following MHRA guidance for valproate prescribing in women of child bearing age: Women are assessed for the need for valproate and treatment is only initiated or continued where absolutely necessary. Women prescribed valproate are informed of its risks in pregnancy, advised to avoid becoming pregnant, offered a contraceptive and prescribed folic acid.

ii) Prescribing for substance misuse: alcohol detoxification

Results of this national audit showed that patients admitted to a SLaM in-patient unit for alcohol detoxification are more likely to have their physical health monitored compared with the national average. However, assessment for Wernicke's encephalopathy and prescription of parenteral thiamine was lower in SLaM than in the national sample.

Actions: The results have been discussed with the Addictions nurse consultant and the doctor leading the audit. An improvement programme has been implemented.

iii) Prescribing antipsychotic medication for people with dementia

NICE guidance recommends against the routine use of antipsychotics for patients with dementia. When considering an antipsychotic the risks must be discussed with the patient and their carers. In addition, antipsychotic use should be regularly reviewed and the indication documented in the patient's notes.

The Trust recently participated in a national audit of the prescribing of antipsychotics for patients with dementia. The results showed that the rate of antipsychotic prescription in dementia was comparable with the average national sample. The indication for antipsychotic prescription was documented for the majority of SLaM patients. Medication reviews were evident for a higher proportion of patients in SLaM than in the average national sample. However, discussions of the risks of antipsychotics use were not evident for many patients in SLaM.

Actions: The results have been discussed with the MHOA CAG. An improvement programme has been implemented.

iv) Monitoring of patients prescribed lithium

Patients prescribed lithium must have their renal and thyroid function tested before starting lithium and at least every six months whilst maintained on treatment. Lithium plasma levels should be monitored at least every six months.

Results of the 2016 National Audit showed that renal and thyroid function tests were completed before lithium initiation for more patients in SLaM than in the national average. However physical health and plasma level monitoring was evident for fewer SLaM patients during maintenance treatment than in the national sample.

Actions: Results have been shared with CAG leads and are being reported in the medicines bulletin.

v) Rapid Tranquilisation

Results of the 2015 audit showed that whilst prescribing for rapid tranquilisation was consistent with trust guidance physical health monitoring after administration of parenteral medication was not evident for all patients. The trust has submitted data for the 2016 national audit of rapid tranquilisation. Results are due to reported by POMH later this year.

In the meantime, we have analysed data locally for a sample of patients who received medication for rapid tranquilisation. There appears to have been an improvement in physical health monitoring, when loosely defined as eyesight observations. However, physical health monitoring as recommended by NICE and the trust guidelines is still poor.

Data for this audit were collected from ePJS. It is possible that as previously suggested, physical parameters are recorded on MEWS chart, which are then not available on ePJS. The introduction of eOBS (electronic MEWS) will improve availability of information on ePJS.

Actions: The recommendations for physical health monitoring following RT (including documentation) have been re-issued to clinical staff. The physical health monitoring audit will be repeated on wards using eOBS.

Other trust-wide patient safety audits and quality improvement programmes

Dose omissions

All doses of medicines prescribed for an in-patient must be administered at the time specified, unless there is a valid reason for the dose being delayed or omitted. The administration box for each prescribed dose must be either signed by the person who administered the dose or annotated with a valid reason for the dose being missed.

The trust conducts an annual survey of the number of doses of regularly prescribed medicines for which the corresponding administration box is blank (neither signed as administered nor annotated with a reason for dose omission).

Results of the 2016 audit showed an improvement from previous years: 0.6% of administration boxes were left blank compared with 1% in previous years.

Actions: Results have been sent to the relevant CAG leads. In addition, ways of improving practice are being discussed by the medicines safety and trust nurse executive committees.

Allergy status documentation

The allergy status for each patient should be documented on the prescription and in the ‘alert’ section of ePJS. Results of the 2016 audit were similar to the previous year: 100% of patients had their allergy status documented on their prescription and in 74% of cases the prescription was consistent with the patient’s recorded allergy status in ePJS.

Action: A project aimed at improving the documentation in ePJS of patients’ medication and allergy status is currently underway. The project group has representation from trust medical, nursing, pharmacy and ePJS teams.

Antibiotic prescribing

Results of the 2016 antibiotic prescribing audit showed that 90% of patients prescribed an antibiotic had the indication for the prescription documented in ePJS. The choice of antibiotic was deemed appropriate for all patients, according to the trust antimicrobial guidelines. Results

have been reported at the trust infection control committee and are included in the medicines bulletin.

vi) CQUIN Indicator 4a: Improving Physical Healthcare to Reduce Premature Mortality in People with Severe Mental Illness (SMI) 2016/17

The Trust participated in data collection and entry onto the NHSE online Webform Portal from December 2016 to February 2017. Confirmation was received from the Royal College of Psychiatrists. Results from the audit are pending.

Results received in 2015/16

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

During December 2015 and January 2016, 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:

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 against the CQUIN is presented as a single percentage figure for each provider, calculated on the basis of the following:

a) The denominator will be the total number of inpatients 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 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).

The data submitted to NHSE is outlined below:

Standard/Indicator	CQUIN SLAM I/P Q4 15/16 Target= 90% (*n*=100)
Monitoring of physical health risk	
Monitoring of smoking	99%
Monitoring of BMI	95%
Monitoring of glucose control	93%
Monitoring of lipids	89%
Monitoring of blood pressure	99%
Monitoring of 5 risk factors in those with established cardiovascular disease	N/A
Assessment of physical activity	43%
Assessment of diet	96%
Assessment of substance misuse	97%
Monitoring of alcohol consumption	97%
Intervention offered for identified physical health risks	
Intervention for smoking	97%
Intervention for BMI >/= 25kg/m2	85%
Intervention for abnormal glucose control	96%
Intervention for elevated blood pressure	88%
Intervention for physical activity	100%
Intervention for diet	91%
Intervention for substance misuse	81%
Intervention for alcohol misuse	67%

Table five: CQUIN Indicator 4a results

vii) 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 (2004-2014). Following a themed review of suicides in SLaM which was completed in 2015/16, a number of recommendations have been implemented, including:

- The launch of a new Risk Assessment Tool on ePJS
- Audits on the management of self-harm have been completed (the findings are outlined below in the Trust Clinical Audit Programme)
- Audits on carers' assessments and care plans have been completed.

Trust Clinical Audit Programme

The reports of 25 local Trust wide clinical audits have been completed in 2016/17 and where relevant, have been reviewed by the appropriate Trust committees for the development of actions to improve the quality of health care provided. A summary of some of the key audits are outlined below.

- **Management of Violence and Aggression: Physical Interventions**

The audit provided insight into practices of physical restraint within inpatient services which the Trust is committed to addressing. Most physical restraints were carried out on men; service users from Black Minority Ethnic (BME) backgrounds; and service users being treated under the MHA.

Physical restraints were mostly prompted by service user to staff aggression. Much of the behaviour which led to the restraint did not have a 'trigger' as such and was thought to be related to the service user being unwell at the time of the incident. However, where triggers were identified these centered around the themes of: medication, other services, property/ items and leave. These themes may be important areas for consideration in taking steps to reduce violence and aggression in inpatient settings.

The Trust has been developing a 'Reducing Restrictive Interventions' Strategy which will provide a sustainable framework for clinical services in the reduction of the use of restraint, prone restraint and seclusion.

The 4-Steps to Safety violence reduction programme continues to be rolled out across the in-patient services.

- **Missing persons' policy for detained patients (AWOL) and informal patients**

An audit was completed in 2016 to assess compliance with the Trust Missing and Absent Persons' policy for detained patients (AWOL) and informal patients, 2015; and to identify any deficiencies in care and make recommendations to address these.

- Care provision was good in respect of reporting the incidents on DATIX, completing risk assessment, recording the AWOL Forms one and two, and reporting patients as missing to the police.

- There was room for improvement for informing the police of high risk informal patients who had gone missing.

- The audit found key focus for improvement needed to be given to the documenting of leave care plans on electronic patient journey system (ePJS) and fact finding reports being completed for C Grade incidents.

The report recommended that leave care plans should be documented and updated as and when necessary in line with Trust policy, as well as improved documentation of risk assessments. The documentation of risk assessments is expected to improve with the new Risk Assessment Tool which was launched on ePJS in January 2017.

The completion of fact finding reports for Grade C incidents is also expected to improve since the launch of the electronic fact finding report on DATIX in April 2016.

- **Seclusion of Service Users**

This report focuses on examining the use of seclusion, compliance of staff to procedures and policy within the SLaM Seclusion Policy version 7(2015) and NICE Violence Guideline (2005). Authority to seclude a service user who is an inpatient has long been recognised as a necessary element in dealing with patients who pose a risk of significant harm to others and staff.

Overall, compliance with policy standards was lower than the performance from the previous Seclusion audit which was completed in 2012.

- There was high compliance around the authority to initiate seclusion, doctors attending reviews after seclusion was initiated, and medical reviews being completed within 30 minutes of seclusion being initiated.

- Most of the service users had a risk assessment completed within the current spell at the time of the incident, and documentation for care plans were adequately evidenced on ePJS.

- The characteristics of the seclusion rooms showed high compliance policy standards.

- More than half of the informal patients were assessed under the Mental Health Act shortly after being placed in seclusion.

- The emergency team was contacted for half of the incidents leading to seclusion.

- Care plans were formulated or updated for just over half of the incidents after seclusion was terminated or following decisions to continue seclusion.

- Service users were rarely informed of the reason for being placed in seclusion.

- Patient observations were inconsistent for all services users.

The report puts forward a number of recommendations aimed to improve the use of seclusion in compliance with the Trust policy. These include regular refresher training for staff; and improved documentation around the duration of seclusion, service user activities and physical observations on ePJS and seclusion forms. Furthermore, evidence of communication with service users regarding the reasons for initiating seclusion also needs to improve.

- **Self-Harm: Longer Term Management**

The NICE Clinical Guideline for Self-Harm: Longer Term Management details the management of single and recurrent episodes of self-harm and the longer term psychological treatment. The 2016 audit was undertaken to provide assurance that standards detailed in the NICE clinical guideline were being adhered to and where compliance was not met, recommendations were made to improve the care provided to service users.

- Care provision was good in respect of assessments of needs and risks, including for older adults and children.

- However, some room for improvement was identified with regards to documenting coping strategies, psychosocial and occupational functioning, and the need for dependent treatment.

- There were also gaps in identifying significant relationships that could affect the level of risk, and long term risks.

- There was high compliance with documentation around care plans and risk management plans.

- Psychological interventions for self-harm was offered for all patients and where appropriate pharmacological intervention alongside this.

- Gaps were highlighted in documentation regarding service user skills, strengths and assets, and employment.

- There were also gaps in documentation regarding occupational rehabilitation.

Following the report, there has been further promotion of the NICE guideline (2011) to psychiatric liaison nurses and doctors in training of recommendations and workshop / training sessions.

The report also recommends the consideration of service user and carer involvement in training to address assessment of coping strategies, protective factors and roles of carers. There should also be improved understanding between liaison teams and occupation therapists of how to assess and address occupational health needs in the liaison setting.

- **Use of Mental Capacity Act (MCA) and Deprivation of Liberty Safeguards (DOLS) audit**

This audit assessed the current compliance with the Mental Capacity Act Policy (May 2015).

- Compared to the previous audit, the report found that fewer service users had a capacity assessment on admission.

- The most common reason for capacity assessments was for medication and treatment.

- There was little documented evidence of how service users were helped to make the decision as independently as possible.

- Best interest meeting documentation was variable, however there were high records of family/carer involvement.

- Staff awareness of the use of MCA and DoLS was high.

Further work in the Trust needs to be done to ensure capacity assessments are completed for all admissions. The report also recommends that service users should be encouraged to make decisions as independently as possible and this should be documented on ePJS.

- **Informal Patient Experience of Admission**

The audit assessed compliance with the Leave for Informal Patient Policy (2016) and if the rights detailed in the 'Being an Informal Patient' leaflet (2016) were being upheld.

- In a majority of cases, patients were allowed to leave the ward when they wanted, and where they were not, reasonable explanations were given.

- Where treatment was refused, this decision was mostly respected.

- A low percentage of service users were aware of their leave care plans.

- The leave poster was displayed on all of the wards visited; however it was not always positioned for obvious sighting.

- It was also found there were variations in the versions of posters being used among the wards.

The report recommends that staff should ensure informal inpatient service users are aware of their leave care plans, and wherever possible be involved in the care planning.

Clinical Academic Group (CAG) leads have also been advised to check the correct Trust Informal Patient poster is clearly displayed on wards.

- **Food Satisfaction Survey**

An audit was completed in 2016 to ascertain patient satisfaction with catering and food provision offered to patients in inpatient services. The audit found:

- The monthly menu display board on the Acute wards was not clear in both content or visually.
- While patients appeared overall to enjoy the food, they stated that the quality of the meal was not always consistent.
- Patients were satisfied with portion sizes.
- There was a poor response regarding access to menu choices except for Forensic services, where patients stated they had both access to a menu and always received what they ordered.
- Child and Adolescent Mental Health Service (CAMHS) patients were less satisfied than the rest of the organisation.

The outcome of the audit will be considered in future tendering processes.

Patients participating in research

The number of patients receiving NHS services provided or sub-contracted by SLaM for the reporting period, 1 April 2016 – 31 March 2017, that were recruited during that period to participate in research approved by a research ethics committee was 2337**.**

Commissioning for Quality and Innovation (CQUIN)

As last year, 2.5 % of SLaM income in 2016/2017 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 2016/17 was £5.6m.

Further details of the agreed goals for 2016/2017 and for the following 12 month period are available electronically at http://intranet.slam.nhs.uk/cquins/default.aspx.

Hospital Episode Statistics Data – HES

SLaM submitted records during 2016/17 to the Secondary Uses 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 2016/ Feb 2017	Out-patients and Community –MHMDS Apr 2016/ Feb 2017 (provisional)
NHS No	98.2%	99.3%
GP Practice code	99.8%	98.1%

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

Information Governance

The Trust's submission for the annual NHS Information Governance Toolkit for 2016-17 demonstrated **91% compliance** with national health and social care information governance standards (all Level 2 or above), which is satisfactory compliance. SLaM annual submission was independently assessed by internal audit with a reasonable assurance outcome.

The Trust is undergoing a digital transformation programme and has implemented a revised Information Governance Operating Model and continued to implement improvements around information governance compliance with national standards and key legislation. All IT staff were trained according to the Control Objectives for Information and Related Technologies (CoBIT) governance framework.

The Trust closely followed the publication of the new Caldidcott Review and the CQC data security review. The recommendations from these national reviews were incorporated in the overall IG action plan. The Local Care Record has been launched with trust's partnership. The Local Care Record (LRC) provides timely and secure sharing of relevant patient information between care professionals to support direct provision of care within King's Health Partners, and GP practices in Lambeth and Southwark.

The Trust joined the NHS Digital care CERTassure programme to develop and implement a robust cyber security programme. The information governance team developed new expertise around privacy, cyber security and risk management. The information risk assurance process was reviewed and updated. The IG team has implemented a dashboard for effective and timely monitoring of IG reviews, investigations and compliance reviews.

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.

Assurance around Information Governance is regularly presented to relevant IG Committees chaired by the Caldicott Guardian, the CCIO (Chief Clinical Information Officer) and the Chief Information Officer. The Board receives quarterly and annual updates on levels of assurance.

Payment by Results Clinical Coding

SLaM was not subject to payment by results clinical coding audit by the National Audit Office during the 2016/2017 financial year. Focus remains on improving the data 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.

Improving Data Quality

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

- Clinical Academic Groups will be working collaboratively with the Business Intelligence and Performance Management teams to improve their data quality.
- Introduction of modern information reporting toolsets to improve access to information
- The Quality Improvement Initiative has raised awareness for the need ensure better data capture.
- Improved design of reports promotes the use of information for service improvement
- Data Quality of Mental Health Services Data Set (MHSDS) and other external submissions are routinely checked prior to the submissions.

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 within 28 days of discharge

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 2014/15	SLaM 2015/16	SLaM 2016/17	National Average 2016/17	Highest Trust % or Score 2016/17	Lowest Trust % Score 2016/17
Not specified (formerly 95%)	97.4%	**96.99%**	**97.1%**	96.2% (Q3)	100%	28.6%

Table seven: Seven day follow-up

The lowest/highest and National Average scores (for a Trust) are based on the Q1-3 scores in 2016/17 published at the time of writing the quality account available at www.england.nhs.uk/statistics

SLaM considers that this data is as described for the following reasons: There continues to be a strong operational and performance focus on this indicator within the Trust.

The Trust performance continues to be comparable with previous years.

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 2014/15	SLaM 2015/16	SLaM 2016/17	National Average 2016/17	Highest Trust % or Score 2016/17	Lowest Trust % Score 2016/17
Number of admissions to acute wards that were gate kept by the CRHT teams	95%	91.5%	**95.9%**	96.5%	98.7 (Q3)	100%	76.0%

Table eight: Access to crisis resolution

The lowest/highest and National Average scores (for a Trust) are based on the Q1-3 scores in 2016/17 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 included in the gatekeeping performance figures for previous years. Following the creation of the Assessment and Referral Centre (ARC) in 2016 with embedded Home Treatment the ARC now acts as the single point of access for the adult care pathway. PLN's now refer to ARC who do the HTT assessment as part of the admission/diversion process.

SLaM considers that this data is as described for the following reasons: SLaM failed to achieve the 95% standard in Quarters 1 and 2. In October the development of the Assessment and Referral Centre (ARC) and standardisation and development of the Home Treatment Teams has led to significant improvements and the thresholds have been met in Quarters 3 and 4.

SLaM intends to take the following actions to improve this indicator score, and so the quality of its services, by further development and embedding of the acute care pathway reconfiguration that has occurred in the financial year. Also to ensure patients get timely access to all settings we must work with our partners which include our local acute hospitals where people may be assessed when distressed.

Re-admissions

The table below provides the emergency readmissions rate within 28 days for adult acute patients. The Health and Social Care Information Centre (HSCIC) has not published results for 2016/17 at the point of writing.

Readmissions to hospital within 28 days of discharge

	SLaM 2014/15	SLaM 2015/16	SLaM 2016/17
Patients readmitted to hospital within 28 days of being discharged	3.95%	2.7%	2.6%

Table nine: Readmissions to hospital

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

The routine monitoring indicator for readmissions for mental health contracts and Clinical Commissioning Groups (CCG) is readmissions within 30 days. The Benchmarking Network for Adult Mental Health report 2015/16 reports that, using a weighted population, the Trust had a 4.3% emergency readmission rate in comparison to a national mean of 8.4% for emergency readmissions within 30 days.

SLaM intends to take the following actions to improve this indicator score, and so the quality of its services, by further development of the Adult mental health pathways.

Service Users Experience of Health and Social Care Staff

	SLaM 2015/2016	SLaM 2016/2017	Highest Trust % or Score 16/17	Lowest Trust % or Score 16/17
Service users experience of Health and Social Care Staff *Scores out of 10*	7.6	7.5	8.1	6.9

Table ten: Service Users Experience of Health and Social care Staff

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

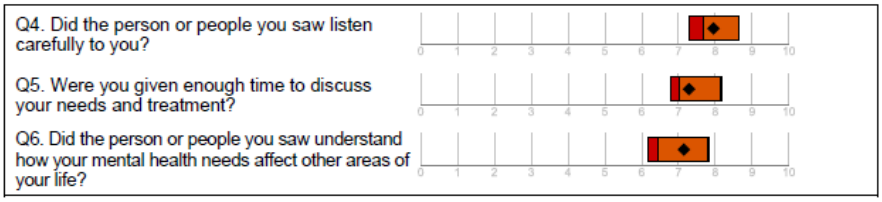
The patient survey responses to the question of how users of services found the health and social care staff of the Trust show that in 2016, overall SLaM scores for this section were about the same as other mental health Trusts. The average Health and Social Care Worker section score for SLaM patients was 7.5 with other Trusts performing in a range of 6.9 to 8.1. Two out of three questions maintained the same score as 2015 (Q4 and Q6), whilst Q5 there was a slight decrease from 7.6 to 7.3.

Survey of people who use community mental health services 2016
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)	2015 scores for this NHS trust	Change from 2015
Health and social care workers							
S1	Section score	7.5	6.9	8.1			
Q4	Did the person or people you saw listen carefully to you?	7.9	7.3	8.6	198	7.9	
Q5	Were you given enough time to discuss your needs and treatment?	7.3	6.8	8.2	199	7.6	
Q6	Did the person or people you saw understand how your mental health needs affect other areas of your life?	7.1	6.2	7.8	190	7.1	

Survey of people who use community mental health services 2016
South London and Maudsley NHS Foundation Trust

Health and social care workers



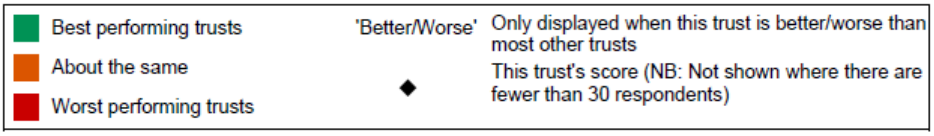


Table eleven: Survey of people who use community mental health services 2016

SLaM intends to take the following actions to improve this indicator score, and so the quality of its services, by ensuring service users are involved in the planning of their care and co-producing a consensus statement for involvement in own care and taking forward a programme plan to deliver on the Trust's Patient and Public Involvement Strategy.

Core Indicators

NHS Improvement was formed in 2016 (replacing the previous Foundation Trust regulator Monitor). NHS Improvement published the Single Operating Framework with effect from October 2016. The framework replaced Monitor's Risk Assessment Framework and introduced new measures whilst discontinuing others or changing thresholds. The Quality Account guidance advises that the indicators included in both of these frameworks should be reported here.

Indicator	SLaM 2016/17	National Target	National Target Met
1. 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	89.7%	75%	✓
2. 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	99.3%	95%	✓
3. Care Programme Approach (CPA) 7 Day follow- up	97.1%	Not specified (formerly 95%)	✓

4. Patients requiring acute care who received a gatekeeping assessment by a crisis resolution and home treatment team in line with best practice standards	96.5%	95%	✓
5. People with a first episode of psychosis begin treatment with a NICE-recommended package of care within 2 weeks of referral	61.9%	50%	✓
6. Data Completeness, Mental Health: identifiers – NHS Number, Date of Birth, Post Code, Gender, GP code, Commissioner code	98.9%	97%	✓
7. Data Completeness, Mental Health: outcomes (for patients on CPA) – accommodation and employment status	57.4%	50%	✓

Table twelve: Core Indicators

Indicators 1 and 2 are based on collated monthly internal Trust reporting, NHS Digital (formerly Health and Social Care Information Centre) will publish full year performance later in 2017/18.

Performance, following a failure to meet 50% in Quarter 1, has been in excess of the target and the Trust's recovery trajectory. For the rest of the financial year.

The indicator percentage of CPA patients with a review in 12 months is not specified within the Single Oversight Framework. The Trust continues to monitor this internally through performance reviews.

The indicator for Meeting commitment to serve new psychosis episodes by early intervention teams indicator has been replaced by the Early Intervention in Psychosis standard.

Delayed Transfers of Care

The indicator 'minimising delayed transfers of care' for mental health trusts is not included in the Single Oversight Framework but the indicator was selected for quality report assurance so therefore is included in the Quality Account; 4.8% of bed days were lost in 2016/17 due to delayed transfers of care.

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.

The process of reporting Trust data to the NRLS and NRLS publication of national data is retrospective by nature. For the latest benchmarked data, SLaM reported:

NRLS Data Q3-Q4 15/16	SLAM 15/16	Average for Mental Health Trusts	Highest Trust % or Score 15/16	Lowest Trust % or Score 15/16
Reported Incidents per 1000 bed days	23.18	42.02	85.06	14.01
Percentage of incidents resulting in severe harm	0.3%	0.4%	2.3%	0.0%
Percentage of incidents reported as deaths	0.4%	1.0%	5.2%	0.1%

NRLS Data Q1-Q2 16/17	SLAM 16/17	Average for Mental Health Trusts	Highest Trust % or Score 16/17	Lowest Trust % or Score 16/17
Reported Incidents per 1000 bed days	22.05	46.02	88.97	10.28
Percentage of incidents resulting in severe harm	0.3%	0.4%	2.9%	0.0%
Percentage of incidents reported as deaths	0.4%	1.1%	10.0%	0.1%

Table thirteen: NRLS (National Reporting and Learning Service) Data

Duty of Candour 2016/2017

Since April 2016, the following measures have been taken regarding duty of candour:

1. A Learning Lessons Half Day event took place at the Ortus on 19.04.17 with over 40 attendees.
2. The PALs service has produced a video aimed at staff which gives advice on how and when to use the duty of candour.
3. The Practical Guide to Structured Investigations training continues to provide education on how and when to use the duty of candour.
4. The Patient Safety intranet website provides practical advice and duty of candour document templates for staff.
5. The mandatory Datix (Trust Incident reporting system) fields for the recording of Duty of Candour were updated in March 2016 and continue to be used and monitored. The entries regarding duty of candour on Datix have been used to inform a re-audit.
6. A re-audit of the duty of candour was conducted and completed in April 2017. Initial findings indicate that since the previous audit in July 2014, the following is to be noted:

<u>Positive points</u>

- Verbal, face to face and written communication with service users and family improved by 37.5% from the previous audit to 82.5%.
- Apologies are being offered more often for both sympathy and admission of responsibility.
- Most cases do record asking the family if they had any questions for the investigation (80%).

Areas for improvement

- Minutes with the service user / family / carer were not recorded for the majority of pre-investigation meetings and required items were not recorded.
- 17.2% of SI cases recorded an offer to meet the service user / carer / family and feedback the investigation, which appears to have slightly decreased from the previous audit.

Governance and Assurance

The Trust has robust operational and quality governance systems and processes in place to monitor the quality of care provided.

The Trust Board receives assurance from the Quality Sub Committee (QSC) chaired by a Non-Executive Director. The purpose is to:

- Provide assurance to the Board of Directors on the delivery of the Trust's Quality Strategy.
- Examine where there have been failures in service or clinical quality and monitor progress against action plans to address them.
- Ensure that there are processes in place to monitor quality effectively.
  - Identify risks related to service and clinical quality and provide assurance to the Board that the principal risks threatening quality are being managed appropriately at all levels within the Trust.
  - Consider issues escalated by the committees accountable to the Quality Sub-Committee.

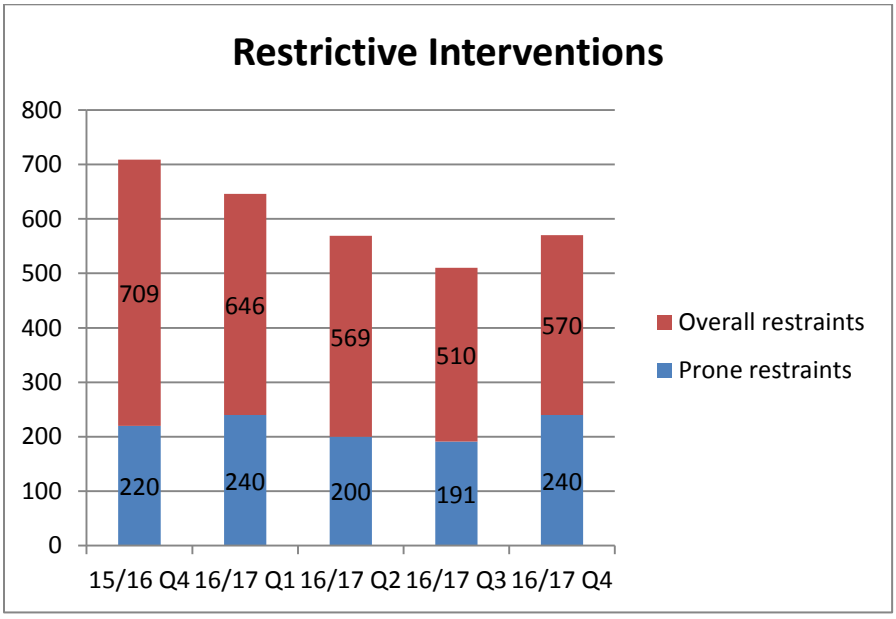
Part 3: Review of quality performance 2016/2017

Review of progress made against last year's priorities

Our 2016/2017 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: Reduce the use of restrictive interventions applied to service users

Target	Reduce any use of restraint that includes prone restraint by 20%. Baseline: 220 in Q4/2017
Measure	Datix incidents in Q4/2016
Headline	**This was not achieved.** Datix incidents in Q4/2017 showed 240 restraints which included prone restraint. Overall, the number of restraints in the Trust have decreased by 19.6%. However, the number of prone restraints have increased by 9.1%



Graph two: Restrictive Interventions

In Quarter 4 2015/16, 31% of all reported restraints were prone. Although the overall number of restrictive interventions used has reduced, 42.1% of the reported restrained in Quarter 4 2016/17 are prone. Positively, the overall data may suggest that in general, the management of

violence and aggression has improved as well as reporting of restraint as per recommendation by the CQC following the comprehensive inspection in 2015 and the quality improvement work carried out as a result.

The Trust internal audit on physical interventions in 2016 found that prone restraint was no longer the most common position used, compared to the findings of the audit completed in 2012.

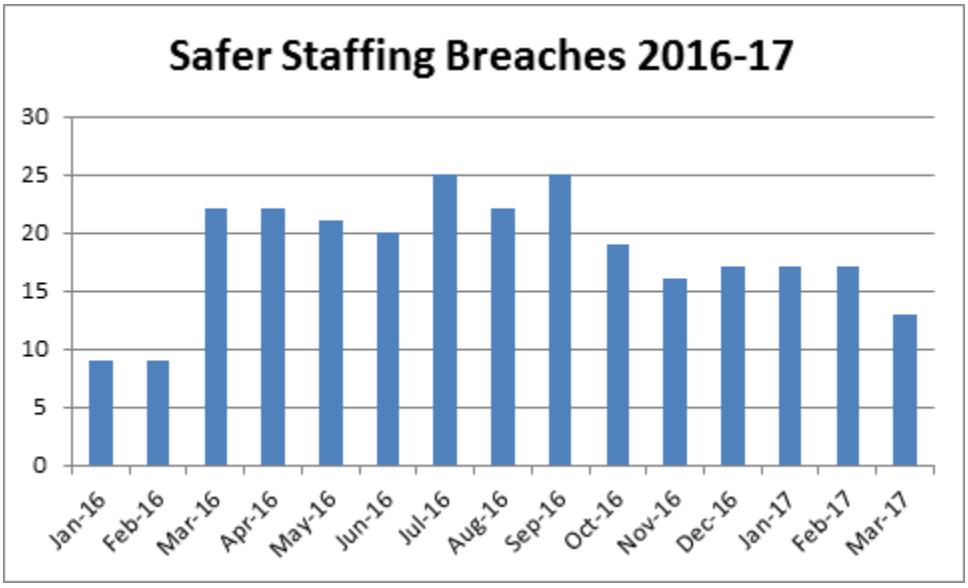
A three year strategy to reduce restrictive interventions has been developed by the Trust and will be ratified in 2017. The strategy provides a framework for the reduction of restrictive interventions across all in-patient services in line with the DH Positive and Safe initiative (2014) and other relevant national guidance including NICE guideline NG10. The strategy delivery is monitored by the Trust Safe and Therapeutic Services Committee.

As part of this strategy the trust is in the process of implementing a violence reduction programme called 'Four Steps to Safety' which is being delivered collaboratively with Devon Partnership NHS Trust and is sponsored by the Health Foundation.

The Four Steps to Safety project is a system for safer care and uses a series of evidence based clinical interventions which are implemented using quality improvement methods. The project aims to reduce the levels of violence and aggression by 50% across all inpatient wards achieving better and safer care for the patients and better, safer working environment for the staff. An important part of the project is to enable clinical staff to embed a system of care which is proactive, rather than reactive. This work was designed and is delivered in partnership with people with lived experience of inpatient services. The programme is being delivered to 48 inpatients wards across the trust and is due to be completed by September 2017.

Priority Two – Patient Safety: Safer staffing

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
Headline	**We did not achieve this target** Between April 2016 and March 2017, the average number of wards with staff breaches per month was 20.



Graph three: Safer Staffing Breaches June 2016 – March 2017

Process and system improvements Recruitment and Retention

The difficulty in recruiting nurses in the capital multi factorial, some of the factors are difficulties beyond local control such as the cost of living in London. We invest time in making advertising campaigns imaginative in order to raise our profile and attract staff. However, this is not enough to make our wards safe. Therefore, SLaM in partnership with London South Bank University, are training Assistant Practitioners an additional workforce to support nurses.

Retaining our nurses requires a multifaceted approach, which includes listening to staff through staff surveys, enabling staff undertake professional development and making provisions for staff wellbeing.

The Trust has worked hard to increase its presence across London and the country. We have attended RCN recruitment Fairs and hosted successful open days at the Bethlem, Kent, Maudsley and Lewisham.

We have had a timetable of monthly assessment centres for Band 5 nurses where we have seen a month on month increase in attendance due to our advertising campaigns in the Metro/Evening Standard and local newspapers.

We have also had a Learning Disability conference to showcase and celebrate the Trusts Learning Disability nurses. It was a widely promoted event. We invited university students and many were expressed an interest to work for the Trust once they qualified.

Nationally, a scheme has been developed to create band 4 Nursing Associate roles, trained at Foundation degree level. Whilst the Trust watches this development with interest, as currently defined, these roles appear better suited for acute general Trusts than Mental Health organisations.

Therefore, in partnership with the other two mental health Trusts who comprise the South London Partnership – Oxleas and South West London and St Georges, an agreement has been reached to take a common approach to the development of band 4 Assistant Practitioners (AP) staff to work in inpatient care areas.

Assistant Practitioners will receive robust training with our partner University, London Southbank University (LSBU), including an initial two week course focusing on mental health practice and then complete a Foundation degree level course via day release for 18 months.

The first cohort of 12 students from SLaM embarked on this course; the first two 'step up' weeks have been completed.

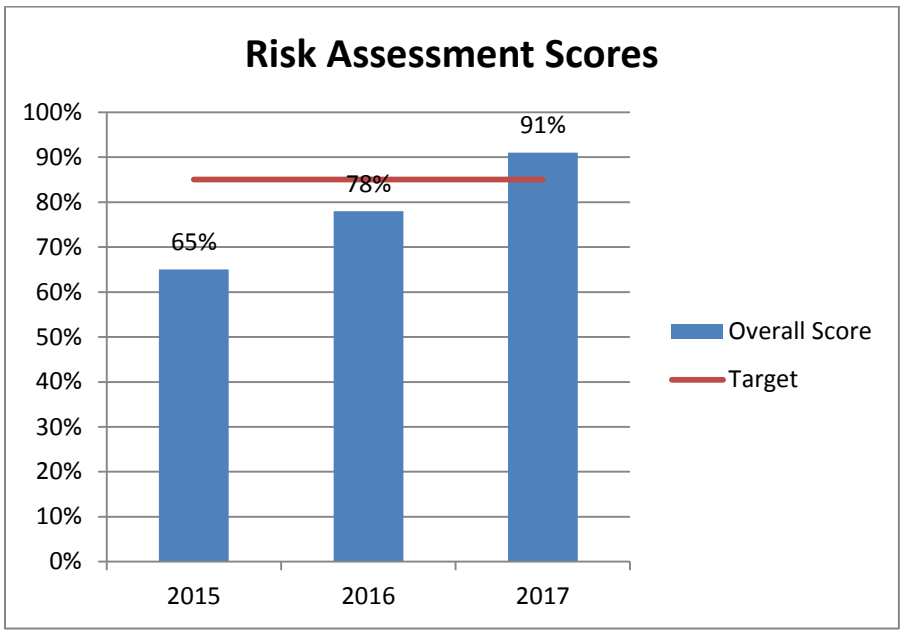
The effect of changes in the workforce will be monitored by seeking service user and staff feedback, and monitoring indicators including complaints and compliments and incident data.

Erostering:

Ward managers regularly attend e –roster efficiency meetings; here they discuss the best practice methods in order to plan staff shifts six weeks in advance. This reduces the level of agency staff. The process and systems within erostering requires continual improvement including building capacity within the team to roll out the SafeCare system across the trust.

Priority Three – Patient Safety: Risk Assessments

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.
Headline	**We achieved this target** The audit sample taken from Q4 achieved 90.8% Inpatient services achieved 95.6% Community services achieved 85.7%



Graph four: Risk Assessment Scores 2015 – 2017

Since 2015, the completion of risk assessments has increased by 26%.

Over the summer of 2016 the trust undertook a comprehensive review and redesign of the ePJS which has helped to ensure the risk assessment process is streamlined, understood and standardised across all clinical services. Completion of risk assessments is audited on a monthly basis and escalated to CAG leadership on a quarterly basis as a governance monitoring structure.

In January 2017, the new Risk Assessment tool went live on ePJS, replacing the previous Brief Risk Screen, Full Risk Screen and Risk Plan. In-patient services were given a 4 week transition period ending in March 2017, and community services were given a 20 week transition period which will end in June 2017.

All clinical staff have to complete risk assessment training every three years as mandatory training and with the development of the new risk assessment template and a standardised audit tool, training is currently being roll out to all clinical staff in our inpatient settings to reflect this.

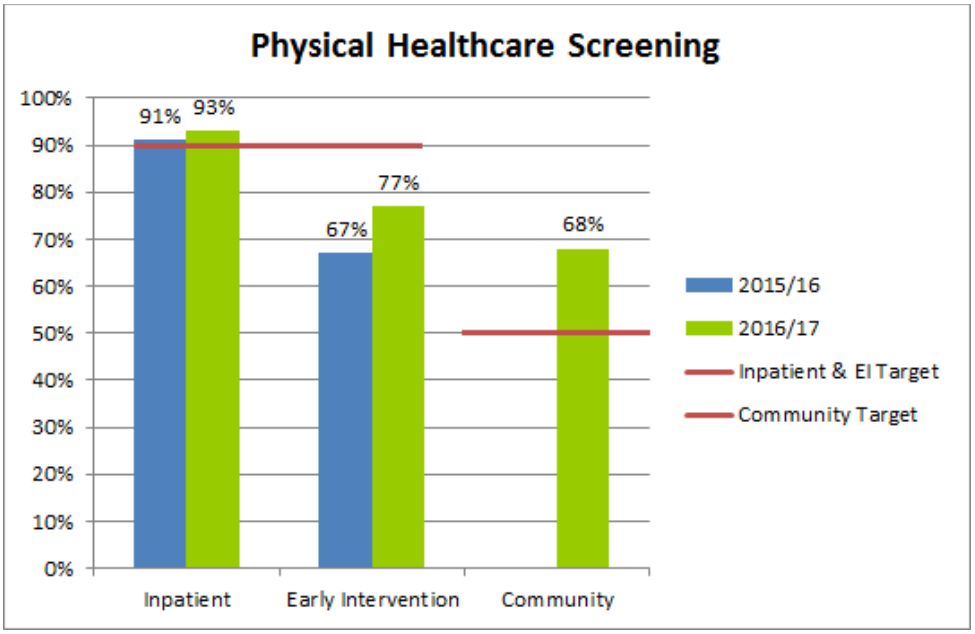
To ensure we are identifying and mitigating against risks associated with individual patients all patients have a full risk assessment within four hours of admission. Risk assessments are reviewed weekly at ward rounds and clinical review meetings, or as required in the case of an event during the patient's stay on the ward. Collaborative risk assessment and management has also been integrated into the inpatient group treatment programme.

The 2017 internal audit found the new Risk Assessment Tool was already in use in 49.4% of the sample.

Priority Four – Clinical Effectiveness: Physical healthcare screening

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; Smoking status; Lifestyle (including exercise, diet alcohol and drugs); Body Mass Index; Blood pressure; Glucose regulation and Blood lipids. They will be 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)
Headline	**We partially achieved this target.** The audit sample taken from August/September Q2 patients achieved 79.3% Inpatients 93%, EIP 77% and Community 68%

In 2016/17, the CQUIN target for physical healthcare excluded Early Intervention service users from the sample. An internal audit was completed to include Inpatient, Early Intervention and Community patients.



Graph five: Physical Healthcare Screening

The internal audit showed improvements in the completion of screening since the previous year and interventions offered. Whilst this is an area of continued focus we are proud of our achievements so far.

Priority Five – Clinical Effectiveness; Care planning

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%
Headline	**We achieved this target.** 89% of service users state that they feel involved in their care (n=10,628) (89.08% to 2dp).

The Trust will maintain and improve on this target by co-producing a consensus statement for involvement in own care and taking forward a programme plan to deliver on the Trust's Patient and Public Involvement Strategy.

Priority Six – Clinical Effectiveness; Developing electronic systems to improve the delivery of care

Target	50% of inpatient teams to embed electronic observations in practice (eOBS); technology to enable paper free patient observations. Baseline: 0 Wards.
Measure	No. of wards using eOBS
Headline	**We did not achieve this target** 2 wards are using eOBS (Johnson and ES2). AL1 has completed training and is ready to start using the new system. 6 more wards are being trained and will be prepared to start implementation in May 2017.

Technical Development

The developers are working towards fully replacing the physical health chart currently being used trust wide to record physical health observations, Modified Early Warning Score (MEWS, with a digital tool.

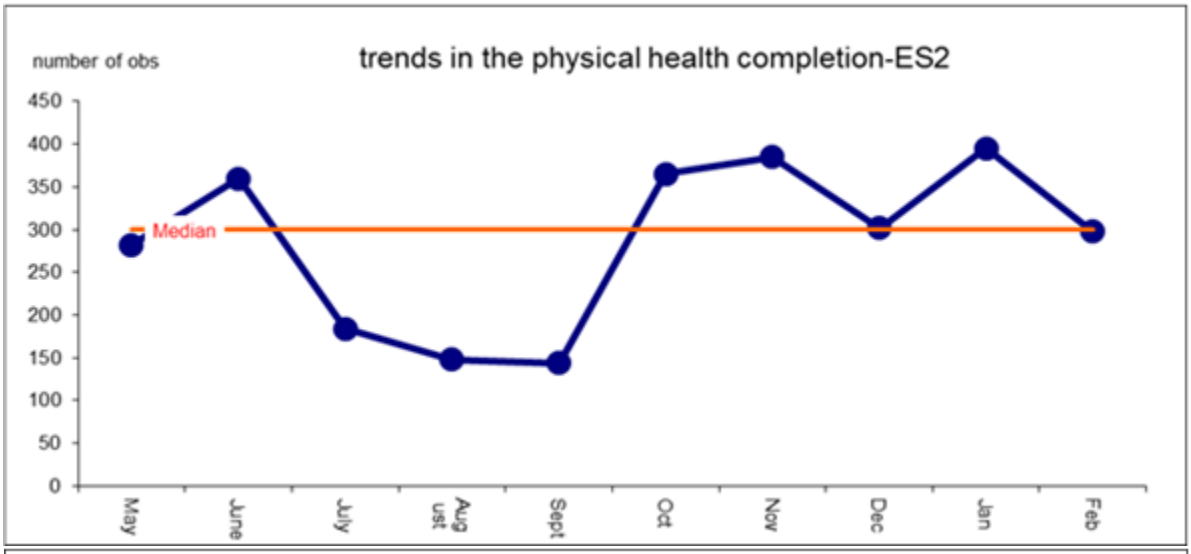
They have alongside this work, been making some improvements to some of the functionalities on the system being piloted on Eileen Skellern 2 (ES2) and Johnson Psychiatric Intensive Care

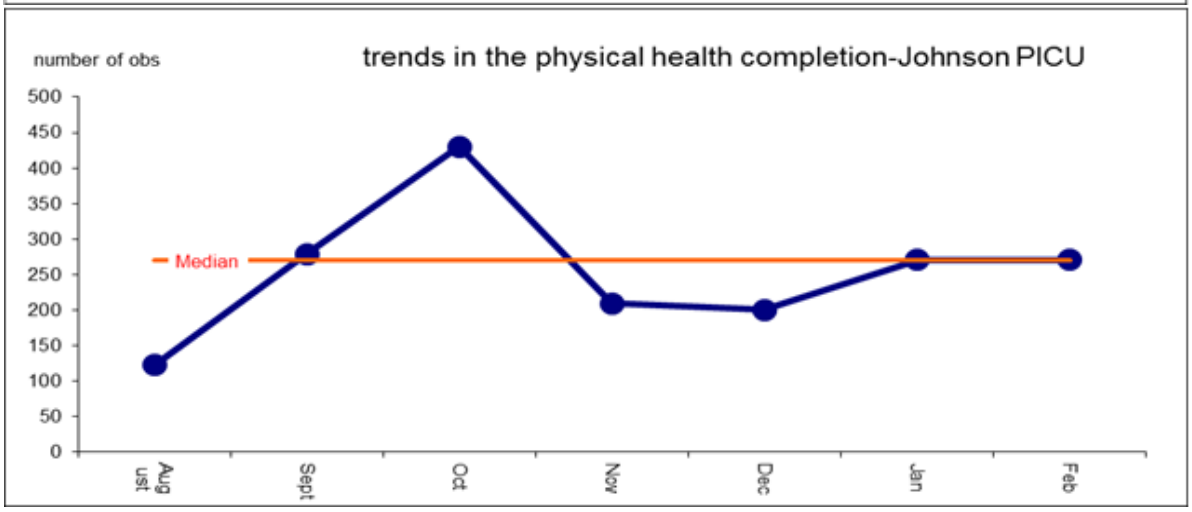
Unit (PICU). The latest release in March, saw some useful additions to the system that both improve its user friendliness as well as the effectiveness in improving the process of recording and accessing meaningful data and alerts that contribute to timely clinical decision making. The full replacement of the paper chart has been delayed by the findings of the pilot and the need to address technical issues. earlier projection.

Wards implementing eOBS:

ES2 and Johnson PICU wards are no longer considered to be pilots wards as eOBS is now fully established into the ward routine and the system is used regularly to carry out physical health observations. Both wards played a significant role in influencing the changes and further developments in the system since the pilot started almost a year ago.

The data available supports the operators feedback that latest upgrade to the software has significantly improved the system usability, this data will continue to be monitored and acted upon. No adverse events or system failures have been reported since both wards started using the electronic system, and neither ward have had to resort to using paper records.





Graphs six and seven: Trends electronic physical health observations in pilot wards

Integrating QI methodology with the roll-out of eOBS.

Aubrey Lewis 1 (AL1), older adults unit is the first ward to be trained to use QI methodology in its implementation of eOBS. The ward manager and a nominated champion had the three days QI training from the Institute of Healthcare Improvement (IHI) followed by training for the whole team on e-Observation and the new physical health tool, NEWS. The ward is also allocated additional support from the QI team to guide them through the process of setting up their PDSAs and measures to monitor improvement. AL1 is now ready to go live once IT support is in place. The learning from their implementation of eOBS using QI methodology will be useful for the roll-out to the rest of the trust.

Trust Roll-Out

The Ladywell site in Lewisham is half-way through the training and preparation for eOBS implementation. It is anticipated that up to 80% of staff in each ward will be trained by the 28th April before implementation can go ahead. Subject to the progress of the software development, implementation will start from the first week of May 2017.

Phase two of eOBS

The second phase of eOBS will be focused on developing the mental health observation tools and the enhancement of the task management functionalities on the system.

This is expected to start from June while the physical health aspect is being rolled out.

Priority Seven – Patient Experience; Reducing the number of Acute out of area treatments

Target	A 40% reduction in the number of adult patients admitted to external providers (overspill). Baseline Figure: Yearly average of 46.1
Measure	This will be measured in monthly performance meetings and data extracted. Complaints data will also be monitored.
Headline	**We did not achieve this target.** Average number of admissions/ transfers to private overspill beds: 2015/16 – 46.1 2016/17 – 40.7 There has been an improvement in the last year, but only a 13.3% reduction.

Whilst this target was not met, a significant amount of work was carried out to improve the patient experience in this area. . The Acute CAG came into existence on 1 July 2016. The remit of the CAG is to provide 24/7 adult acute care across inpatients and home treatment teams.

In November 2016 the Acute care CAG published its two year plan. Over the last six months the acute and PICU wards across the four hospital sites have been looked at in terms of admission rates, length of stay, number of beds, nurse staffing ratios and multidisciplinary input, with a view to developing a two year plan to standardise our offer to people who use in patient services. A new Acute Referral Centre (ARC) has been formed to create a single administrative

point for acute admissions. The service operates 24 hours a day, 7 days a week for 365 days per year. ARC staffing consists of a clinical service lead, a crisis line practitioner, home treatment clinicians and a patient flow co-ordinator. The purpose of the Acute Referral Centre is to ensure that referrals for patients requiring a crisis or acute response are directed swiftly and offered the most appropriate intervention without delay.

Ensuring the most appropriate treatment without delay for all will enhance quality and effectiveness. This is a key strategy to reduce reliance on out of area (overspill) beds.

	2015/16	2016/17
Average for the year (external plus McKenzie)	46.1	40.7

Table fourteen: Overspill averages 2015 to 2017

The Trust intends to reduce the average length of stay from 45 days to 40 days, which in turn will contribute to preventing external overspill.

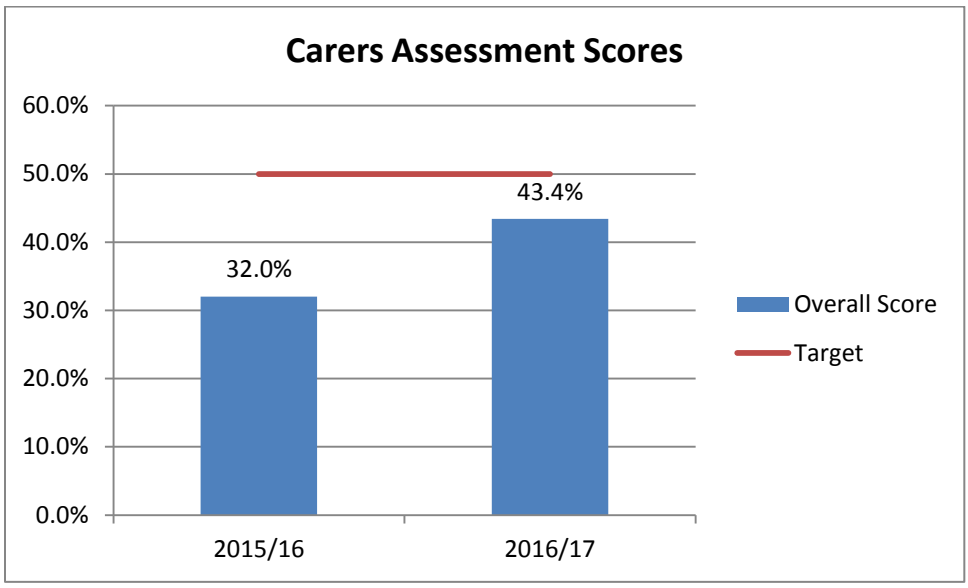
Throughout 2017/18, through a series of quality improvement projects we aim to further reduce the average length of stay to 35 days.

Getting the average length of stay to 35 days and creating four acute wards for each borough (as well as the PICU provision and the early intervention ward) will allow the wards to run at 85%, with a target four hour wait time for admission.

In 2018/19 we plan to further decrease the length of stay to 30 days. Once this is achieved the CAG executive believe that this will be a good time to further review the skill mix of staff on the wards.

Priority Eight – Patient Experience; Carer's assessments and associated care plan

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.
Headline	**We did not achieved this target.** The internal audit achieved 43.4% 43.4% of identified carers were offered a carers' assessment.



Graph eight: Carer Assessment Scores 2015-2017

The previous audit undertaken in 2016 showed performance in offering carers' assessments was 32% and an action plan was sought to address this poor performance and achieve a target of 50% by April 2017.

A key challenge of this work has been to design an assessment tool which was tailored for the needs of mental health carers but also complied with the Care Act and was able to be developed on the ePJS system. Following involvement from carers and staff, a 'carers' engagement and support plan' was developed on ePJS and went live at the end of November 2016 and the old forms were removed. This tool enables staff to assess the presenting needs of the carer, offer advice, information and support and share the support plan with the carer. The tool has links to the four borough local authority forms and guidance on how to access a formal carers' assessment under the Care Act if one is indicated. Staff feedback on the forms has also been encouraged and received and will be used to make further design improvements.

In order to have local leadership and ownership of carers' assessments, each CAG nominated a carers' lead to help to develop the tool and to champion carers' assessments in the CAGs to facilitate an improvement in performance. The initial launch of the forms was, in general, positively received by staff and since the end of November 2016, approximately 300 carers' engagement and support plans have been completed.

However, the current Trust-wide position of patients on CPA with an identified carer offered a carers' assessment is 42.5%. 6.3% of the assessments completed used the new form. Carers' assessments and care planning will continue to be a quality priority in 2017/18, and further work will be completed to promote the use of the new Carers' engagement and support form.

Priority Nine – Patient Experience – Quality of environments and food within in-patient services

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.
Headline	**We achieved this target.** The Trust scored 95% overall for the PLACE audits. The food audit score was lower than the previous year and equal to the national average (88.07%). However, all other audit scores were higher than the national average.

	Cleanliness	Food	Condition, Appearance & Maintenance
Trust Score 2016	99.26%	88.07%	97.84%
National Average 2016	98.06%	88.07%	93.37%
% above National Average	1.20%	0.00%	4.47%

Table fifteen: PLACE audit scores 2016

We involved our service users in assessing the quality of our care environment as part of the PLACE inspection between February and June 2016.

A team made up of service users, staff and an external assessor from another trust inspected 40 of our wards.

We have exceeded national averages in every PLACE assessment area except 'food', and are taking action to address this. Having changed menus, we currently maintain the national average for food. We are looking to improve this by refining our current catering and domestic food contracts and moving to fully cooked fresh food in Spring 2017.

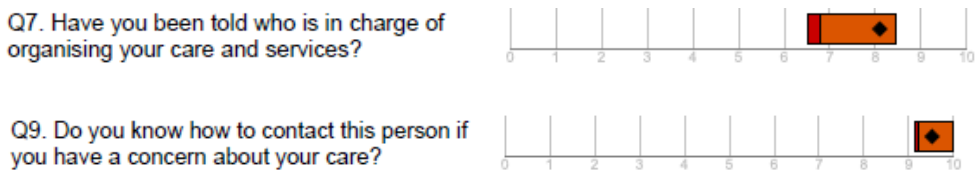
The patient environment and the settings in which we deliver our clinical services is a clear factor in good healthcare delivery. Through PLACE assessments we demonstrate a clear commitment to delivering a well maintained, clean and safe environment for everyone who uses our services.

National patient survey of people who use community mental health services: SLaM report 2016

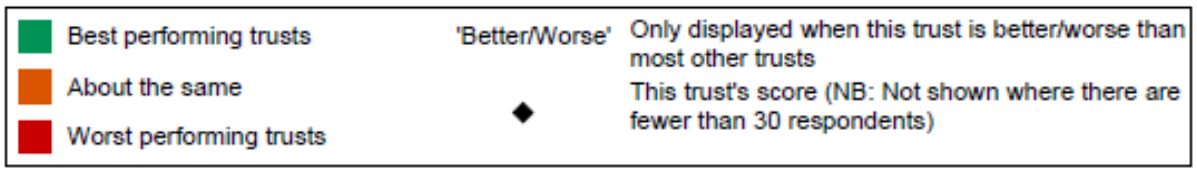
The National Patient Survey was returned by 206 SLaM patients giving a response rate of 26%; this is slightly lower than the national average response rate of 28% for all mental health trusts. SLaM performed 'about the same' as all other trusts nationally for every question in the 2016 survey of people who use community mental health services and therefore 'about the same for each separate survey section.

SLaM's highest three performing questions are as follows:

Section 2: Organising care



Section 7: Treatments



Graph nine: SLAM's patient survey highest three performing questions

The three questions where the Trust had the greatest increase in performance in 2016 compared to 2015 are providing help or advice with finding support for finding or keeping work (+11.2%), knowing who to contact out of office hours if you have a crisis (+10.1%) and being involved as much as the service user wanted to be in discussing how their care is working (+4.6%).

To build further on these improvements the Trust has reviewed the approach to Patient and Public Involvement (PPI). The PPI policy was endorsed by the board in December 2016. The policy sets out a governance structure for involvement by people who use services and their friends, families and carers at all levels of the organisation to ensure a consistent approach across all parts of the organisation.

A new Involvement Oversight Group with Non-Executive Directors, service user and carer governors as well as staff attending has been set up to ensure that the policy is implemented and adhered to thereby improving the quality of services we provide. This group reports to the Quality Sub Committee

We are proud that we increased the number of respondents to FFT and other service user questionnaires by 50% since 2014/2015.

National Staff Survey 2016 – Results

1832 staff at South London and Maudsley NHS Foundation Trust took part in this survey. This is a response rate of 40% which is below average for mental health/ learning disability trusts in England, and compares with a response rate of 38% in this trust in the 2015 survey.

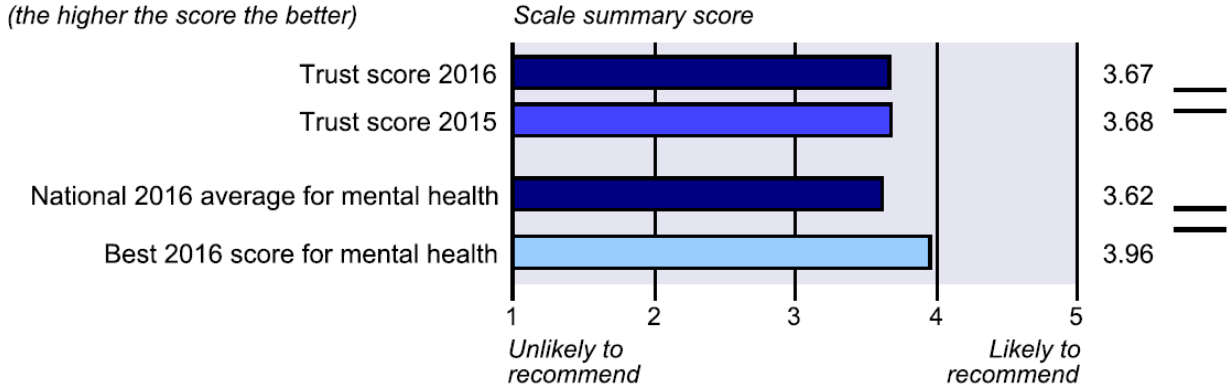
Number of Staff recommending the Trust

In the 2016 survey, SLAM performed slightly lower to 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 3.67 compared to the national average score of 3.62 for other mental health trusts.

		Your Trust in 2016	Average (median) for mental health	Your Trust in 2015
Q21a	"Care of patients / service users is my organisation's top priority"	72%	72%	72%
Q21b	"My organisation acts on concerns raised by patients / service users"	74%	74%	72%
Q21c	"I would recommend my organisation as a place to work"	58%	56%	59%
Q21d	"If a friend or relative needed treatment, I would be happy with the standard of care provided by this organisation"	61%	59%	60%
KF1.	Staff recommendation of the organisation as a place to work or receive treatment (Q21a, 21c-d)	3.67	3.63	3.68

Table sixteen: National staff survey results

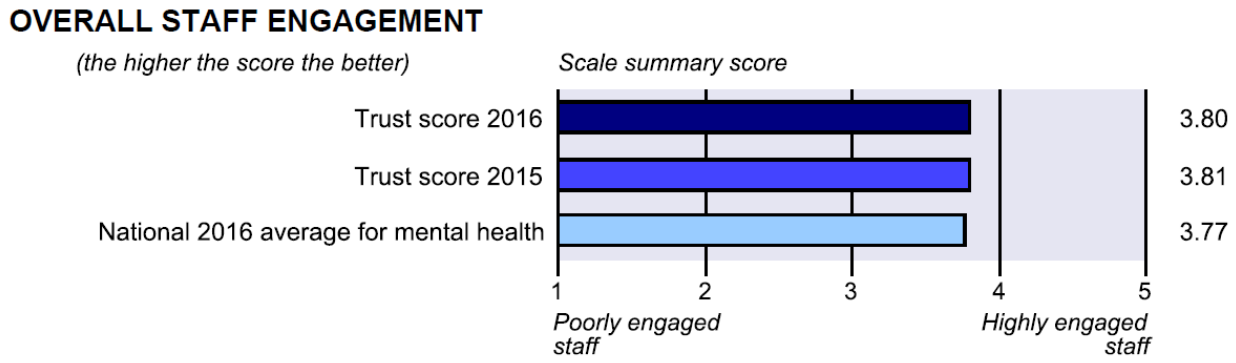
KEY FINDING 1. Staff recommendation of the organisation as a place to work or receive treatment



Graph ten: National staff survey results – key finding 1

Overall Staff Engagement

The Trust score for overall staff engagement has gone down marginally to **3.80** (3.81 in 2015). This is higher than the national average for all mental health/learning disability Trusts which was 3.77.



Graph eleven: National staff survey results – overall staff engagement

Key Findings – overall Trust

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

- Percentage of staff appraised in last 12 months.
  Trust Score: 93% **National Average: 89%**

- Effective use of patient/ service user feedback (scale summary score).
  Trust Score: 3.82 **National Average: 3.70**

- Percentage of staff/ colleagues reporting most recent experience of violence
  Trust Score: 95% **National Average: 93%**

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

- Percentage of staff attending work in the last 3 months despite feeling unwell because they felt pressure from their manager, colleagues or themselves (the lower the score the better)
  Trust Score: 53% **National Average: 55%**

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

- Percentage of staff satisfied with the opportunities for flexible working patterns
  Trust Score: 51% **National Average: 59%**

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

- Organisation and management interest in and action on health and wellbeing (Scale summary score)
  Trust Score: 3.56 **National Average: 3.71**

- Percentage of staff believing that the organisation provides equal opportunities for career progression or promotion
  Trust Score: 78% **National Average: 87%**

- Percentage of staff reporting good communication between senior management and staff
  Trust Score: 30% **National Average: 35%**

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

- Percentage of staff working extra hours (the lower the score the better)
  Trust Score 2016: 76% **Trust Score 2014: 81%**

- Percentage of staff experience physical violence from staff in last 12 months (the lower the score the better)
  Trust Score 2015: 3% **Trust Score 2014: 5%**

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

- Percentage of staff appraised in last 12 months
  Trust Score 2016: 93% **Trust Score 2015: 96%**

Workforce Race Equality Standard

- Percentage of staff experiencing harassment, bullying or abuse from staff in last 12 months
  White **Trust Score 2016: 24%** **Trust Score: 2015: 23%**

  BME **Trust Score 2016: 27%** **Trust Score 32%**

Over the past year following on from the previous Staff Survey we have been actively engaging with and supporting the development of the new BME network. This has included the development of a "Tackling Snowy White Peaks" Working group following on from a network event where Roger Kline presented his findings on his research into Snowy White Peaks in the NHS.

The group has been looking at particular issues and themes and have developed a "Reflect and Review" checklist to be used before any formal investigation is undertaken. This will enable managers to take a step back and look at whether there are better alternatives than formal action.

A review of disciplinary investigation outcomes has been conducted on those staff involved in a formal disciplinary process and from a Black African background as there were are a greater proportion going through formal disciplinary processes. It is recognised that the Reflect and Review checklist may assist in ensuring that staff are only taken through a formal process where there is no alternative.

We are presently scoping the implementation of a programme of inclusive leadership which helps organisations think about the impact and implications of unconscious bias. It is intended that we may be in a position to conducting a trial or pilot later in the year.

In the previous Staff Survey report it was highlighted that the Trust was is in the worst 20% in terms of the percentage of staff who experience physical violence from other staff. In September 2016 the Chief Executive wrote an open letter to all staff reminding them of the need to report any incidents of unacceptable behaviour from other staff and to use the mechanisms already available to escalate any matters. It is positive to see a reduction in these reported in the 2016

survey which is also identified as one of the most improved areas but there is still further work to do to make this zero.

At a local level, each CAG and Directorate will again 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 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 have seen a reduction in the overall percentage appraisal scores which is a little disappointing and although the score is higher than the national average and a good achievement we need to strive to ensure this is better than the 96% in the previous year over the forthcoming year. We have introduced a new learning development system which will also provide the platform to record and report on appraisals over the forthcoming year.

Freedom to Speak up Guardian

The Trust has appointed a Freedom to Speak Up Guardian. A Steering Group has been established to oversee a body of work which includes a refreshed promotion and cultural change programme. This follows the visit of the National Guardian on 17th March 2017. There are a number of Ambassadors and Advocates and the aim is to increase the visibility and encourage everyone in the Trust to see 'Speaking Up and Being Heard' as business as usual. Two reports have been made to the Board and the third is scheduled for June 2017.

SLaM Equality Information and Objectives

The Trust published its annual equality information in January 2016. This includes 2016 Trust-wide equality information that provides information on the demographic profile of the Trust's service users and the experience of service users with different protected characteristics.
We also continue to publish local ethnicity reports for Croydon, Lambeth, Lewisham and Southwark. These provide information on the ethnicity of service users accessing 11 of the Trust's services and the experience of service users of different ethnicities in each borough.

The Trust has developed new CAG equality objectives for 2017-20. A high-level summary of these is provided below:

- **Acute Care CAG:** To improve access and experiences for service users with learning disabilities in acute wards.
- **Addictions CAG:** To improve access to substance misuse services in Wandsworth for men who have sex with men.

- **Behavioural and Developmental Psychiatry CAG:** To improve the physical health of Black and Minority Ethnic service users in forensic inpatient services.

- **Child and Adolescent Mental Health CAG:** To improve access and experiences for Asian and Black girls in CAMHS community services.

- **Mental Health of Older Adults and Dementia CAG:** To achieve earlier access to memory services in Lambeth and Southwark for Black service users.

- **Psychological Medicine and Integrated Care CAG:** To improve access and outcomes for Black service users in Lewisham Improving Access to Talking Therapies [IAPT] service.

- **Psychosis CAG:** To ensure equitable access to early intervention services for people aged 35 and over**.**

Glossary

Acute Out of Area Treatments (OATs)	An Acute Out of Area admission is when a service user is admitted to an Acute inpatient ward which is located outside of the funding CCG's (See Clinical Commissioning Group entry) area.
Adult Mental Health Model (AMH)	The Adult Mental Health Model (AMH) is a the model used within SLaM to treat people with mental illness, the model focusses on preventing illness and taking a holistic approach to treatment i.e. physical, social and mental health care.
Biomedical Research Centre (BRC)	The Biomedical Research Centre (BRC) is a research centre formed by the National Institute for Health Research (NIHR) (see National Institute for Health Research entry). The Maudsley BRC is in partnership with SLaM, the Institute of Psychiatry, Psychology and Neuroscience at King's College London. The BRC has a number of research themes including Bioinformatics and statistics.
Care Programme Approach (CPA)	The Care Programme Approach (CPA) is a type of support that a person might receive or be offered if they have mental health problems or complex needs. The Care Programme Approach is inclusive of: an assessment of needs, a care plan, regular review of your needs and the care plan and a Care Co-ordinator.
Care Quality Commission (CQC)	The Care Quality Commission (CQC) is a health and adult social care regulator in England. The CQC inspects services based on five Key Lines of Enquiry, these are: safety, effectiveness, caring, responsiveness and well-led.
CareCERTassure	Cyber security programme led by NHS Digital to improve cyber defences in line with Cyber Essentials Plus scheme. SLaM is an early adopter.
Chief Clinical Information Officer (CCIO)	Deputy Medical Director for Information
Clinical Academic Group (CAG)	SLaM is divided into "Clinical Academic Groups". Services fall into particular CAGs depending on who they treat and what treatment they provide. The Trust's CAGs are as follows: **Acute:** provides care to people who experience a mental health crisis and need to be home treated or on occasion admitted to hospital. **Addictions:** provides community services to adults with drug and alcohol disorders. **Behavioural and Developmental Psychiatry (BPAD):** Provides Forensic and neurodevelopmental services to adults. **Child and Adolescent Mental Health Services (CAMHS):** Provides a range of mental health services for children and young people. **Mental Health for Older Adults (MHOA):** Provides services to those either: over the age of 65 with dementia or severe and complex mental health needs or under the age of 65 who develop dementia **Psychological Medicine and Integrated Care (Psych Med):** Provides clinical care across mental and physical health through the General Hospital Liaison services with four acute hospitals. Psych Med also provides specialist services i.e. Mother and Baby, Eating Disorders Service, Chronic Fatigue, Neuropsychiatry, and Psychosexual Conditions. **Psychosis:** Provides early intervention services, acute inpatient services, community services promoting recovery, and a range of rehabilitation services as well as two national specialist services.
Clinical Commissioning Groups (CCG)/Commissioner	A Clinical Commissioning Groups (CCG) (also known as Commissioners) "are clinically-led statutory NHS bodies responsible for the planning and commissioning of health care services for their local area." (*About CCGs, NHS Clinical Commissioners*). SLaM is commissioned by Croydon, Lambeth, Lewisham and Southwark CCG.
Control Objectives for Information and Related Technologies (CoBIT)	IT governance and management framework which covers risk management, assurance and audit, data security, governance and governance

Commissioning for Quality and Innovation (CQUIN)	Commissioning for Quality and Innovation (CQUIN) is a payment framework whereby quality improvement goals are linked to financial reward.
Datix	Datix is the incident reporting system which SLaM uses for the recording of incidents and complaints.
Deprivation of Liberty Safeguards (DoLS)	The Mental Capacity Act allows restraint and restrictions to be used – but only if they are in a person's best interests. Extra safeguards are needed if the restrictions and restraint used will deprive a person of their liberty. These are called the Deprivation of Liberty Safeguards.
Electronic Observation Solution (eOBS)	Electronic Observations Solution is the digitalisation of patient observations (vital signs) also known as early warning signs (MEWS) as opposed to the use of paper MEWS Charts.
Electronic Patient Journey System (ePJS)	ePJS is the electronic system that SLaM uses to document patient notes.
Health and Social Care Information Centre (HSCIC)	The Health and Social Care Information Centre (HSCIC) is a public body which produces national data for health and social care with the aim of improving care. The HSCIC is sponsored by the Department of Health.
Health Service Journal (HSJ)	The Health Service Journal (HSJ) is a website and serial publication which covers topics relating to the National Health Service and Healthcare.
Healthcare Quality Improvement Partnership (HQIP)	The Healthcare Quality Improvement Partnership (HQIP) is an independent organisation which aims to promote quality in healthcare and increase the impact of clinical audit (see Audit entry). HQIP is led by the Academy of Medical Royal Colleges (see Academy of Medical Royal Colleges entry), The Royal College of Nursing (see Royal College of Nursing entry) and National Voices (see National Voices entry).
Hospital Episode Statistics (HES)	Hospital Episode Statistics is a data repository held by the Health and Social Care Information Centre (see Health and Social Care Information Centre entry) which stores information on hospital episodes i.e. admissions for all NHS trusts in England.
Local Care Record (LCR)	An secure integrated portal between SLaM, GSTT, KCH and 90+ GP practices in Southwark and Lambeth electronic health records, which provides instant real-time access to health records to care professionals during direct care.
Mental Capacity Act (MCA)	The Mental Capacity Act (MCA) is designed to protect and empower individuals who may lack the mental capacity to make their own decisions about their care and treatment. It is a law that applies to individuals aged 16 and over.
Mental Health Services Data Set (MHSDS)	The Mental Health Services Data Set (MHSDS) is a data set held by the Health and Social Care Information Centre (see Health and Social Care Information Centre entry) which contains care data relating to the people who use mental health services. It is mandatory for NHS Trusts to submit data to the MHSDS.
National Confidential Inquiry into Suicide and Homicide by People with Mental Illness (NCISH)	NCISH is a National Confidential Inquiry into Suicide and Homicide by People with Mental Illness which collected suicide data in the UK from 2003-2013 (The National Confidential Inquiry into Suicide and Homicide by People with Mental Illness Annual Report 2015: England, Northern Ireland, Scotland and Wales July 2015. University of Manchester). It is commissioned by the Healthcare Quality Improvement Partnership (see Healthcare Quality Improvement Partnership entry).
National Health Service England (NHSE)	National Health Service England (NHSE) is a body of the Department of Health (see Department of Health entry) which leads and commissions NHS services in England.
National Institute for Health Research (NIHR)	The National Institute for Health Research (NIHR) is the body which oversees research in the NHS.
National Reporting and Learning Service (NRLS)	The National Reporting and Learning Service (NRLS) is a system which enables patient safety incident reports to be submitted to a national database which is designed to promote understanding and learning.
Quality Sub Committee (QSC)	The Quality Sub Committee is the Committee within SLaM which is responsible for the monitoring of serious incidents and complaints, clinical governance. Other Trust Committees such report to the Quality Sub Committee.
Patient Led Assessment of	Patient Led Assessment of Care Environment (PLACE) assessments are annual

Care Environment (PLACE)	assessments of hospital environments which evaluate: cleanliness, food and hydration, privacy, dignity and wellbeing, condition, appearance and maintenance and dementia.
Prescribing Observatory for Mental Health -UK (POMH-UK Audits)	The Prescribing Observatory for Mental Health UK audits are National Clinical Audits (see National Clinical Audit entry) which assess the practice of prescribing medications within mental health services in the United Kingdom.
Safecare (HealthRoster)/E-roster	Safecare HealthRoster also known within SLaM as e-roster is the e-rostering system designed by Allocate Software (see Allocate Software entry) and used within SLaM to complete shift rostering and record sickness, absence and competencies for all staff.