South London and Maudsley NHS Foundation Trust

DRAFT
Quality Account for 2018/2019

This is a draft Quality Account report and further information to be included following validation.

South London and Maudsley NHS Foundation Trust in numbers

230 COMMUNITY, INPATIENT AND OUTPATIENT SERVICES

NUMBER OF STAFF
4,800

INTERACTIONS WITH PATIENTS BASED ON LOCAL CLINICAL COMMISSIONING GROUP (CCG) 31 MARCH 2018

Lambeth CCG	Croydon CCG
328,185	241,155
Lewisham CCG	**Southwark CCG**
264,611	247,941

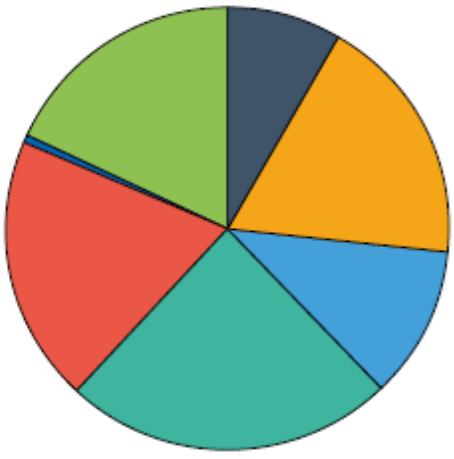
Across all four boroughs, around half of our contacts with patients are through face to face appointments, with the remaining number being a combination of emails, letters and telephone calls

We serve a population of **1.3 million** people

Treat **64,067** patients in the community

Provide **3,700** people with inpatient care

786 BEDS ACROSS 8 INPATIENT SITES



Average numbers of employees (wte basis)

Medical and dental	447
Administration and estates	976
Healthcare assistants and other support staff	604
Nursing, midwifery and health visiting staff	1,274
Scientific, therapeutic and technical staff	1,037
Social care staff	42
Agency and contract staff	948

Fig. 1: Trust in numbers

TRUST WORKFORCE ETHNICITY

2,669	192	317	1,211	213	92
WHITE	MIXED	ASIAN OR ASIAN BRITISH	BLACK OR BLACK BRITISH	OTHER ETHNIC GROUPS	NOT STATED

74

COMMUNITY SITES

We employ around **5,338** permanent staff

604 Healthcare assistants and other support staff

1,274 registered nurses

948 temporary staff employed across the year

1,037 scientific, therapeutic and other technical staff

447 medical and dental

976 administration and estates staff

Proud of our diverse workforce - over **40%** of our workforce are from a BME background

£381m

TURNOVER 2017/18

£10.5m

SURPLUS 2017/18

Over 75% of communications from our community teams to GPs includes a discussion about a service user's physical health

85%

WOULD RECOMMEND US TO FRIENDS AND FAMILY

96%

SAY THEY FOUND STAFF TO BE KIND AND CARING

Our 49 governors, 15,203 Trust members and external partners help us to prioritise our objectives every year

The number of partnerships with international organisations is increasing and we provide a number of clinical services and educational programmes in Europe, the Middle East and China.

In London we provide community and inpatient mental health services in Croydon, Lambeth, Lewisham and Southwark.

We provide drug and alcohol (addictions) services in Bexley, Greenwich, Lambeth and Wandsworth.

We also provide a series of partnership services working with other NHS organisations, local authorities, criminal justice services and the third sector.

Across the UK we provide approximately 50 national and specialist services for children and adults.

In Kent we provide specialist child and adolescent mental health services.

Fig. 2: Trust in Numbers

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Part 1: Statement on quality from our chief executive - DRAFT

The annual quality account report is an important way for the Trust to report on quality and demonstrate our commitment to improving the services we deliver to our service-users, their families, their carers and our local communities.

As a large, diverse mental health trust providing local and national services, we aim to make a difference to lives by seeking excellence in all areas of mental health and wellbeing: prevention, care, recovery, education and research. This year we refreshed the changing lives strategy with five strategic aims; Quality, partnership, a great place to work, Innovation and Value to help achieve this aim.

Each year we work with our commissioners, the CCGs, to agree funding available to provide mental health services in the boroughs we serve. The CCGs have worked with us to ensure that across Lambeth, Lewisham, Southwark and Croydon we have an increase this year that will enable us to invest in improving services and continue to work towards the quality and performance standards set out in the 5 year forward view. This year the Trust has received a 6.6% uplift across all of its CCG contracts for 2019/20.

Our priority now is to work with services to ensure investments are made in the right place to have most impact for the people that use our services and for our staff. Of course, to make this new investment count we must continue to carefully manage our existing resources and to ensure that we deliver real value – better outcomes for every pound we have to spend – for the people we serve.

SLaM continued its leadership role in joint working at system-level, covering 3.6 million people, through the South London Mental Health and Community Partnership (SLP), alongside Oxleas and South West London and St George's. Particularly significant progress was made in improving Adult Forensic patients' experience and care outcomes; providing care locally for CAMHS Tier 4 patients previously placed outside south London; and developing skills and improving retention rates across the south London NHS mental health nursing workforce. The SLP's work continued to deliver millions of pounds of savings for

reinvestment in local services through improved commissioning, new services and clinical pathways, and has been recognised for innovation and best practice in national awards and by NHSI, NHSE and CQC.

It is becoming clearer and clearer that we have a shared challenge within our local communities linked to mental health and emotional vulnerability which is approaching critical public health proportions. At the same time, we are on the cusp of being able to transform our understanding, identification and treatment of mental health issues in children and young people. A new partnership between SLaM, the IoPPN, KHP and the Maudsley Charity is seeking to radically transform our understanding, identification and treatment of mental health problems in children and young people.

The project's vision is for an ambitious programme of research, clinical innovation and education across three key themes – mother and baby, brain development, and contemporary childhood. The programme will connect clinicians and researchers working across SLaM and the IoPPN in a range of localities. It will also support the creation of a brand new centre at Denmark Hill. It will be supported in part by the Trust's first major fundraising campaign, which will launch in September 2019.

Finally, our workforce is our most valuable asset and it is imperative that all staff feel valued, supported and engaged in order to provide the highest quality of service. Feedback from the Staff Survey and the BME Network indicates that the experiences by our BME staff are reported as less positive. Diversity and inclusion are core to the delivery of good high quality services by motivated and engaged staff and therefore the Trust Board has set the Organisation the challenge by Spring 2021 to improve the experience of our BME staff by setting some clear goals and objective sin this area, including improved representation of BME staff in senior positions and improved career opportunities.

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

ADD IN BOROUGH ALLIANCES

Trust Vision

> Everything we do is to improve the lives of the people and communities we serve and to promote mental health and wellbeing for all - locally, nationally and internationally.

Trust Strategy

During 2018 we refreshed our Trust Strategy which is named 'Changing Lives' because everything we do is to help people to improve their lives. The refreshed strategy was approved by the Board in September 2018 and launched in October 2018.

This strategy builds on the direction of travel set out in our previous strategy, with five strategic aims that include a strong focus on the quality of our services. These are:

Fig. 3: Trust strategic aims

2018/2019 quality priorities

The quality priorities set for 2018/2019 below incorporated the broader quality domains of patient safety, clinical effectiveness, both patient and staff experience. Progress against these priorities are outlined later in this report. These areas continue to be priorities for 2019/2020.

Fig. 4: 2018/19 quality priorities

Care Quality Commission (CQC)

Below highlights the current Trust CQC rating.

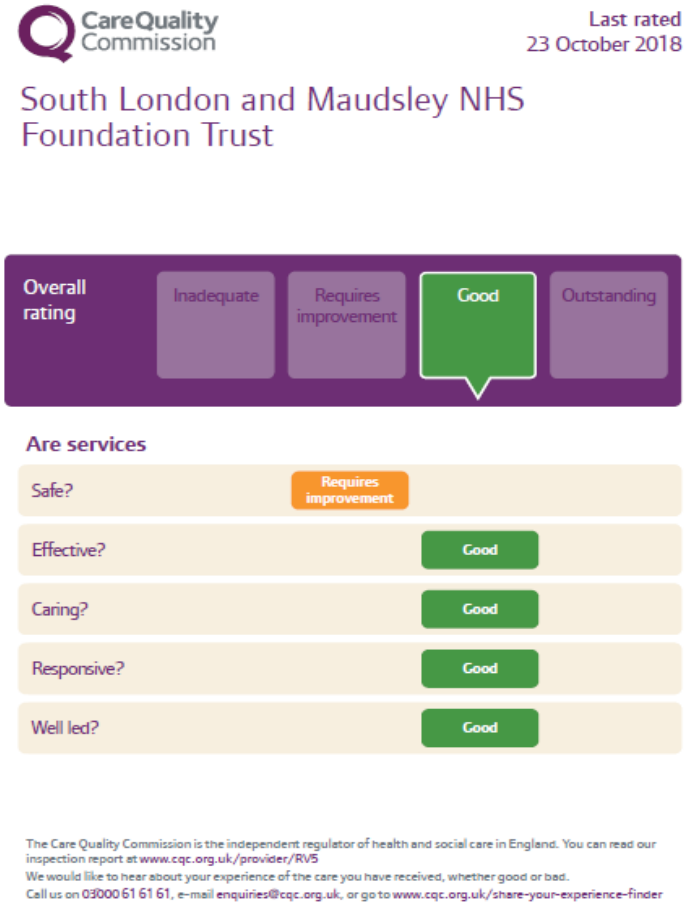


Fig. 5: Current trust CQC rating

Service user involvement

SLaM's Recovery College had 569 new students in the past year, with a total of 3,186 students participating since its launch with Maudsley Charity funding in 2014. Students consist of:

- People who use SLaM services
- Supporters (carers, family and friends) of SLaM's service users
- People who have been discharged from SLaM services within the last six months and their supporters
- Anyone working with SLaM as a volunteer or peer supporter or who is on the Involvement Register
- SLaM staff (not including students on clinical placement).

The workshops and courses aim to provide the tools for recovery through a learning approach that complements the existing services provided by the Trust. Every course and workshop is co-designed and co-run by trainers with lived experience working alongside trainers from the mental health profession.

The trust runs an Involvement Register as a way for the trust to advertise and allocate opportunities to people who want to use their experience of using our services to help us to develop and improve them in the future. The trust's Peer Support scheme provides additional support to people leaving services from people with a lived experience.

There are currently 350 active volunteers across the Trust, of which approximately 47% have had lived experience. Volunteers make a valued contribution to many areas and services across the trust, including inpatient wards, administration and reception areas, phlebotomy, community group befriending, football group volunteers, IT support for service users, peer support befriending, Bethlem Community Café, Bethlem Museum of the Mind and Gallery, and gardening.

Part 2: Review of quality performance 2018/2019

Review of progress made against last year's priorities

Our 2018/2019 quality priorities were selected after consultations with stakeholders and staff from our services and are highlighted below:

Fig. 6: Quality priorities 2018/19

The following summarises progress made against each priority over the year. The priorities set for 2018/19 were three-year targets to allow for systems to embed and afford real sustained improvement. Therefore whilst targets have not been achieved fully in 2018/19, good systems have been embedded and progress

has been made, such as around care plans. The metric indicators to measure performance in the key

	Trust wide		CAMHS	Croydon & BDP	Lambeth	Lewisham	Southwark & Addictions	PMOA
	17/18	18/19						
Reducing violence by 50% over 3 years								
Reducing violence by 50% over 3 years	4158	4372	659	1198	665	661	812	377
Reduction in restraint by 50% in over 3 years	1716	1789	357	386	257	275	396	118
Reduction in prone restraint – zero by 3 years	708	549	40	92	80	134	188	15
Reduction in the use of rapid tranquilisation by 25% in 3 years	840	772	25	143	140	173	224	47

priorities are outlined below:

Patient safety

How did we do?

The number of reported incidents of violence and aggression appears to be on an increasing trajectory. With a focus on restrictive practice and violence reduction it is expected that the quality of the data will improve and thus is likely to increase before reducing again. At present, Trust wide data do not show any indicators of change however there have been local areas of change, for example, an area of particularly good performance is the reduction in use of prone restraint in the Lambeth directorate.

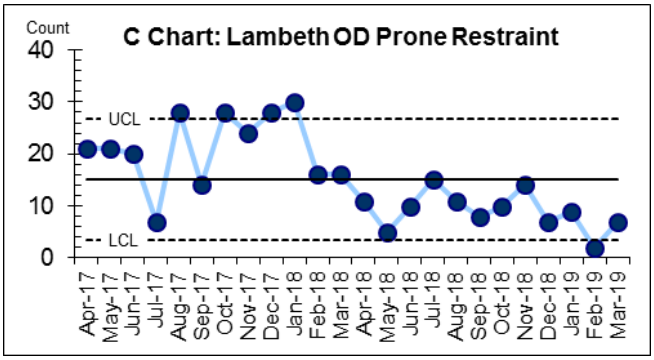


Fig. 8: Lambeth OD Prone Restraint

The main focus with the work around Rapid Tranquillisation has been to ensure that where it is being used in the Trust it is done so safely and with appropriate physical health monitoring. An area of good performance is in Lewisham directorate, which may be seeing a downward shift in the rates of rapid tranquillisation usage, including a two week period in the male PICU where no rapid tranquillisations were used at all.

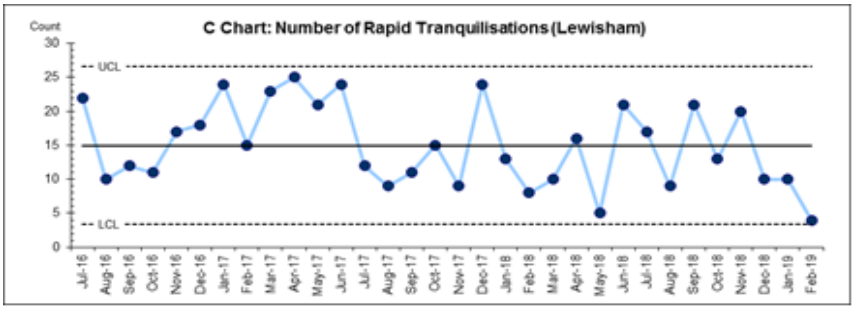
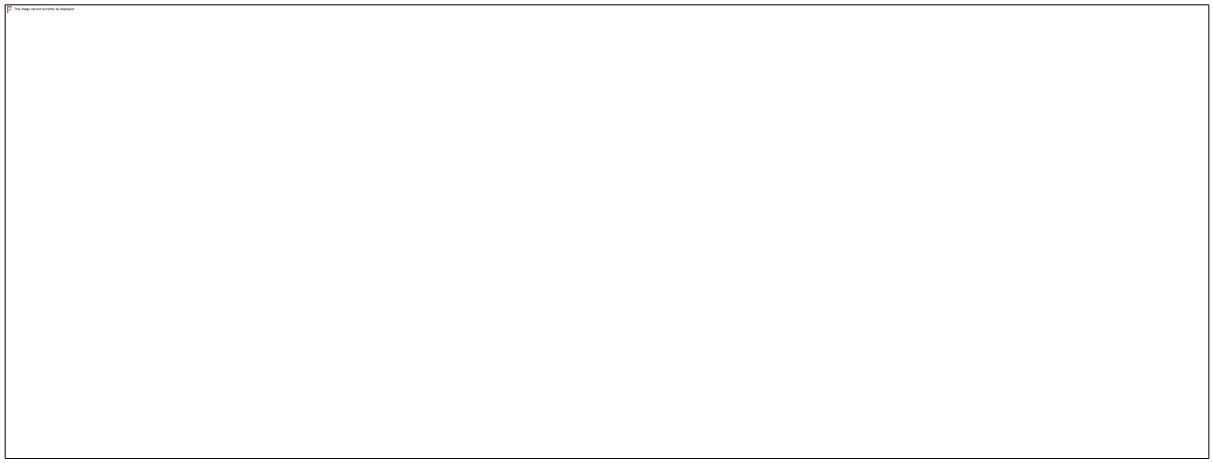


Fig. 10: Lewisham OD Rapid Tranquilisation

	Trust wide		CAMHS	Croydon & BDP	Lambeth	Lewisham	Southwark & Addictions	PMOA
	17/18	18/19						
Right care, right time in appropriate setting								
Reduction in the amount of time waiting from referral to first assessment. (Days)	45	47.8	88.62	71.72	20.78	21.90	16.78	64.56
Reduction in crisis readmissions by 10%	311	295	19	80	56	55	71	14

How did we do?



ICare is a trust wide Quality Improvement (QI) programme within the general adult care pathway (inpatient and community). There are three work streams:

1. Patient safety
2. Standardised ways of working
3. Patient flow and capacity

Inpatient operational care process model

Inpatient Care Process Model (CPM) and expectations of community in the adult acute inpatient care pathway ow)

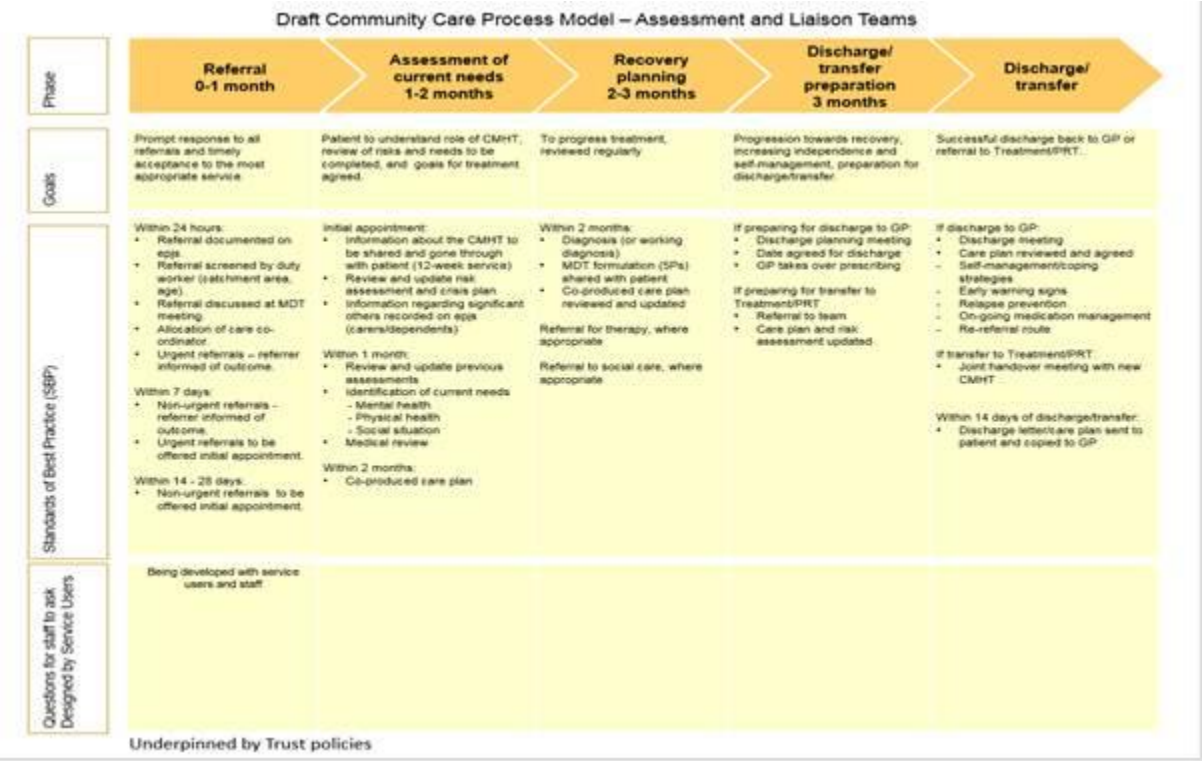
The inpatient CPM has taken ten months to develop and is being tested in Lewisham, prior to scale up and spread across the Trust. The first phase is collecting baseline data with staff and service users and carers to identify which standards of best practice are being demonstrated and the focus for priorities for improvements. Initial tests will focus on the admission and discharge elements of the process in order to prioritise the improvement in flow.

Community CPM (see visual below)

Several engagement events were held throughout 2018 with staff, service users and carers, and partner organisations to inform the development of the Community Care Process Model. Feedback from these

Service user and carer involvement

events, along with data, have formed the basis of the community care process model (CPM) that is being drafted with clinicians, service users and carers from Southwark community teams, where the model will initially be tested.



CPM Model- Draft Community Care Process Model- Treatment/Promoting Recovery Teams

Fig. 7: Progress against quality priorities 2018/19

	Trust wide		CAMHS	Croydon & BDP	Lambeth	Lewisham	Southwark & Addictions	PMOA
	17/18	19/20						
Service User and carer involvement								
Increase number of identified carers/ friends/family for person in receipt of care	50.3%	51.1%	64.3%	42.5%	63.6%	65.5%	58.2%	51%
Increase in the number of care plans over the next three years that have been co-produced with the service user and the contents shared with them. Target: 100%	54.3%	78%	85%	77%	58%	60%	75%	64%
Increase the number of positive responses to 90% over the next three years regarding patients recommending the service to friends and family if they needed similar care or treatment	85%	85.36%	85.55%	81.42% (Croydon) 82.13% (BDP)	80.02%	81.03%	78.81% (Southwark) 93.93% (Addictions)	92.65%

How did we do?

Carer Engagement- Increase in identified carers

This year work was completed with Business Intelligence to establish a reporting mechanism to broaden the terminology for identifying carers to include Carer, Family member, Children's Guardian, nearest relative, next of kin, Resident and Non-resident parent, Friend, recognising that not everyone identifies with the word carer.

There has been communication with the Service Directors/Clinical directors and the Carers leads in each directorate.in preparation for the Quality compliance meetings to discuss ways to increase the number of identified carers.

Work streams to help with improvement in this area, included:

Work with communications to raise awareness for "Think Carer" month

Directorates to remind staff / do a drive for the month to complete field on EPJ re contact information – role and relationship (provided guidance/rationale).

If directorates have carers leads/ champions on wards for example, consider doing a snapshot audit of completion of contact form completion for identified carer or family – identify gaps and complete as appropriate, feedback on ideas to improve. Work ongoing in the directorates to engage and work with families and carers and examples of this could be promoted.

Co-produced Care plans

This year has seen a continued effort by clinical services to improve in the numbers of care plans being co-produced with service users. Ongoing monitoring of this by monthly audits has seen an increase during the year and was identified as an improvement in the recent 2019 CQC inspection.

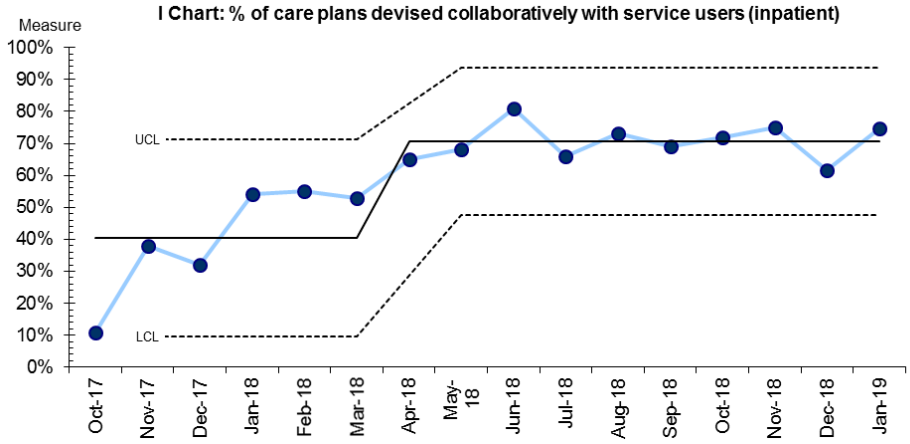
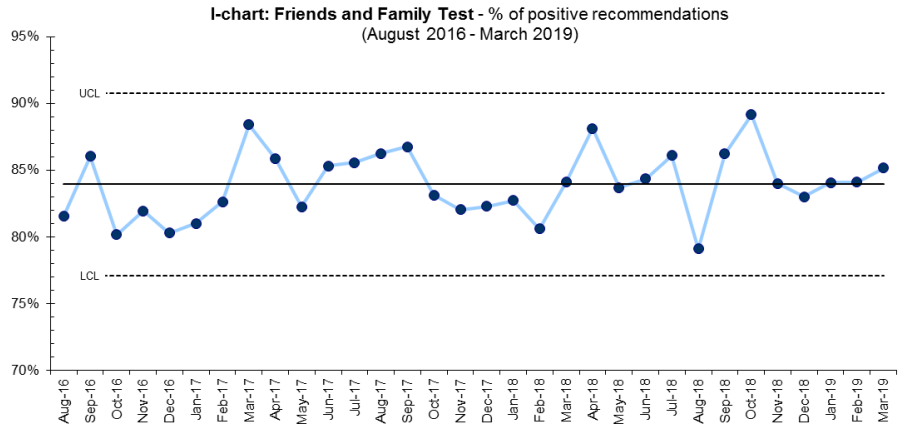


Fig. 11: Percentage of care plans co-produced with service users (Trust wide – inpatient)

Friends and Family Test

The trust collects approximately 12,000 FFT responses annually. It is available in several formats to aid collection of opinions from different patient groups, such as easy-read for Learning Disabilities and child- and adolescent-friendly formats. The trust's FFT score sees peaks twice a year when the Addictions directorate complete their bi-annual push for responses. The trough in August 2018 was due to a temporary issues with the freepost address which paper surveys are returned to. The FFT score has been maintaining or exceeding the median line for the past two quarters. The trust has a number of projects in development to improve FFT performance, which includes the co-production of a dementia-friendly survey, launching in the Place of Safety, development of a trust PEDIC dashboard in Power BI, and a project to validate some new core PEDIC questions. These new questions have been developed with staff, service users and the IoPPN to ensure the questions are consistently interpreted across patient groups, valid and reliable, which will make it easier for people to give us feedback. The trust has also been part of the national working group for the review of the FFT with NHS England.



Safer staffing and staff experience

	Trust wide		CAMHS	Croydon & BDP	Lambeth	Lewisham	Southwark & Addictions	PMOA
	17/18	18/19						
Staff experience								
Reduce turnover of staff by 10% in a rolling year over next 3 years	18.6%	18.9%	26.76%	19.69%	17.8%	13.17%	14.06%	17.99%
Increase the number of positive responses to 75% over the next three years of the number of staff who would recommend SLaM as a place to work	60%	58.9%	N/A	N/A	N/A	N/A	N/A	N/A
Increase the number of positive responses to 75% over the next three years of the number of staff who, if a friend or relative needed treatment, would be happy with the standard of care provided by the organisation.	61%	58.6%	N/A	N/A	N/A	N/A	N/A	N/A

How did we do?

The newly designed Operations Directorate leadership teams are recruited to and have gained traction. The teams clearly know their wards and teams well and are sighted on the quality issues of which staffing is a part. Recruitment activity continues in earnest and through the General Managers, the Matrons and the Heads of Nursing we are ensuring that ward teams have the support they need to recognise and deliver the expected standards of care.

Actions to improve staff experience are detailed in the Trust's Staff Survey Action Plan and include the following:

- Executive visibility walkabouts
- Changing Lives Roadshows
- Staff fora
- Flexible working policy and HR oversight of requests
- E-Rostering
- ICare
- Wellbeing strategy
- Schwartz rounds
- BME and Lived experience networks
- Transparency in acting up and secondments
- Four Steps to Safety
- Various local QI projects
- Reinforcing the bullying and harassment policy with a personal message from the CEO
- Promoting FTSU

In addition we have added a local question to the Friends and Family Test (FFT) about perceptions of career progression and promotion based on ethnicity. This is one of the three key aspirations of the Workforce Race Equality Standard (WRES) action plan. It is recognised that this question is only asked once per year so in order to gain more regular feedback it has been included in the quarterly FFT survey.

SLaM scored 'about the same' as most other trusts that took part in the 2018 National Community Mental Health Survey. One survey section scored 'better' than most other trusts, related to changes in who people see (7.3/10). A total of five questions increased on 2017 scores (two significant shifts; a shift of 5 or more), 20 decreased (ten significant shifts) and for three there was no change. One individual question scored 'better' than most other trusts in relation to changes in who people see having a positive impact upon care (8.2/10) and was also one of the two questions with a significant shift upwards. A total of two questions scored 'worse' than most other trusts in 2018 (care organisation and involvement in agreeing what care will be received; 7.4/10 and 6.6/10 respectively). The scores for the top two rankings on the overall experience question stayed the same as last year (16% 10/10 and 11% 9/10). When comparing SLaM scores against other London-region trusts only, SLaM scored within the highest 20% for two survey sections (health and social care workers and changes in who people see) and within the lowest 20% for six sections.

Section	Significant shift upwards	Score
Support and wellbeing	Have NHS mental health services involved a member of your family or someone else close to you as much as you would like?	6.7
Changes in who people see	What impact has this had on the care you receive?	8.2

Fig. 12: National community mental health survey – questions with significant shift upwards

Section	Top five performing questions	Score
Organising care	Do you know how to contact this person if you have a concern about your care?	9.4
Changes in who people see	What impact has this had on the care you receive?	8.2
Organising care	Have you been told who is in charge of organising your care and services?	7.8
Overall views of care and services	Overall, in the last 12 months, did you feel that you were treated with respect and dignity by NHS mental health services?	7.8
Treatments	Were these NHS therapies explained to you in a way you could understand?	7.6

Fig. 13: National community mental health survey – top five performing questions

Section	Bottom five performing questions	Score
Support and wellbeing	In the last 12 months, did NHS mental health services give you any help or advice with finding support for physical health needs?	5.3
	In the last 12 months, has someone from NHS mental health services supported you in joining a group or taking part in an activity?	4.7
	In the last 12 months, did NHS mental health services give you any help or advice with finding support for financial advice or benefits?	4.1
	In the last 12 months, did NHS mental health services give you any help or advice with finding support for finding or keeping work?	3.7
	Have you been given information by NHS mental health services about getting support from people who have experience of the same mental health needs as you?	3.6

Fig. 14: National community mental health survey – bottom five performing questions

The survey free-text comment themes largely reflect the trust's other experience feedback. The theme care and treatment received the most free-text comments (35.71%), of which the largest sub theme was that people had a general positive experience of their treatment (n=17) and excellent care (n=17). The largest number of negative comments related to wanting more support from staff (n=10) or more sessions (n=9). There were also many comments about staff, of which most were positive (n=28) with some negative comments regarding staff turnover and staffing levels (n=5). The theme with the largest number of negative comments was appointments and access, with 17 comments regarding long waiting times.

Overall, when comparing the national survey results with local trust feedback, including the trust-wide survey programme (PEDIC), it seems that respondents to the 2018 national survey generally reported a more negative experience. This apparent discrepancy could be due to a number of reasons such as small sample size and differences in sample population, methodology and timeframe. As such, services should consider these results in conjunction with other feedback mechanisms and in light of any actions that have taken place in the time following the data collection period. This will enable the findings to be incorporated into local improvement initiatives. To further improve experience of services, the Trust continues to implement the Patient and Public Involvement (PPI) strategy and report to the Service User Involvement and Family and Carers Committees, which in turn report to the Quality Committee.

National Staff Survey 2018

In 2018, 1939 staff across the Trust took part in this survey. The response rate was 43% which is below the average for mental health/learning disability trusts in England (54%) and compares with a response rate of 44% last year.

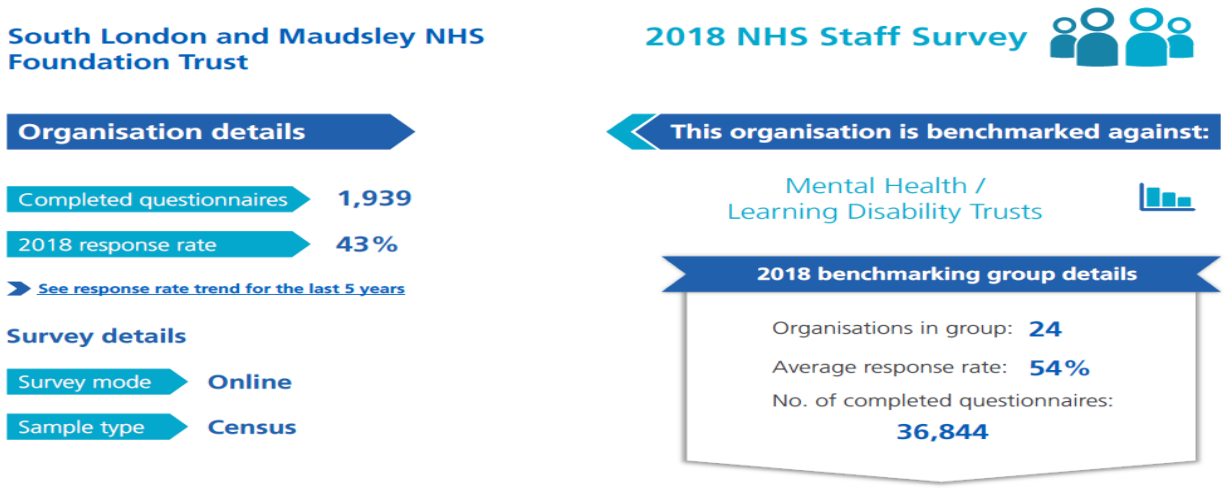
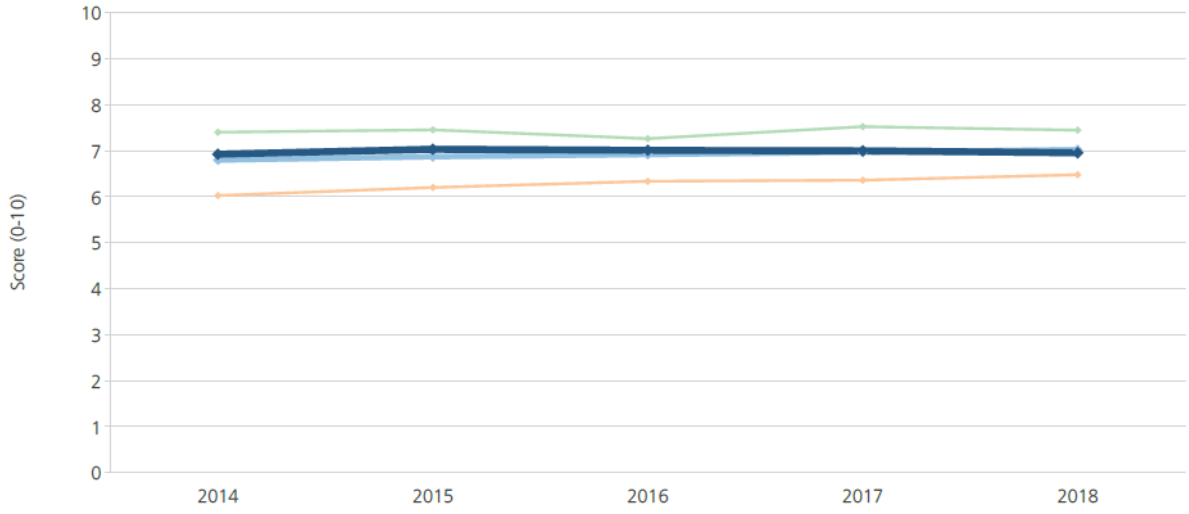


Fig. 15: 2018 NHS Staff survey details

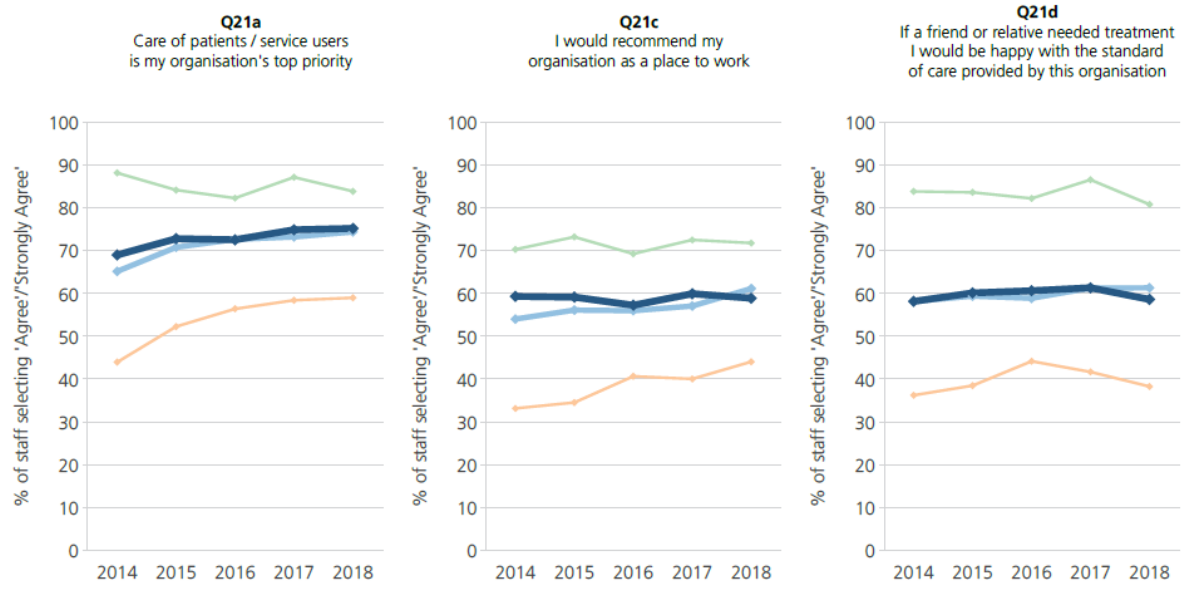
Overall Staff engagement

Below the Graph highlights Trust performance with staff engagement overall. SLaM performed alongside the average score of 7.0 and the same as 2017.



	2014	2015	2016	2017	2018
Best	7.4	7.5	7.3	7.5	7.4
Your org	6.9	7.0	7.0	7.0	7.0
Average	6.8	6.9	6.9	7.0	7.0
Worst	6.0	6.2	6.3	6.4	6.5
No. responses	1,752	1,689	1,814	1,872	1,919

Fig. 16: 2018 NHS Staff survey results – staff engagement



	Q21a 2014	Q21a 2015	Q21a 2016	Q21a 2017	Q21a 2018	Q21c 2014	Q21c 2015	Q21c 2016	Q21c 2017	Q21c 2018	Q21d 2014	Q21d 2015	Q21d 2016	Q21d 2017	Q21d 2018
Best	88.1%	84.2%	82.3%	87.1%	83.9%	70.3%	73.2%	69.2%	72.5%	71.8%	83.8%	83.6%	82.2%	86.5%	80.8%
Your org	69.0%	72.8%	72.5%	74.9%	75.2%	59.3%	59.1%	57.2%	59.9%	58.9%	58.1%	60.1%	60.6%	61.3%	58.6%
Average	65.1%	70.8%	72.6%	73.2%	74.3%	54.0%	56.1%	55.9%	57.0%	61.1%	58.1%	59.4%	58.9%	61.2%	61.3%
Worst	43.9%	52.2%	56.4%	58.4%	59.0%	33.1%	34.5%	40.6%	40.0%	44.0%	36.2%	38.4%	44.1%	41.6%	38.2%

Fig. 17: 2018 NHS Staff survey results – detailed staff engagement theme

Key Findings – Overall Trust

Theme	2017 score	2017 respondents	2018 score	2018 respondents
Equality, diversity & inclusion	**8.6**	1786	**8.3**	1853
Health & wellbeing	**6.0**	1825	**5.7**	1875
Immediate managers	**7.1**	1824	**7.1**	1886
Morale		0	**5.9**	1843
Quality of appraisals	**5.7**	1653	**5.5**	1717
Quality of care	**7.3**	1603	**7.3**	1625
Safe environment - Bullying & harassment	**7.8**	1758	**7.7**	1831
Safe environment - Violence	**9.0**	1753	**9.1**	1818
Safety culture	**6.7**	1801	**6.6**	1862
Staff engagement	**7.0**	1872	**7.0**	1919

Fig. 18: 2018 NHS Staff survey results – key findings

There are some similarities between the Trust's overall results and the national picture. Nationally there are disappointing scores in relation to health and well-being, bullying and harassment, increases in the areas of stress and musculo-skeletal problems, and worsening perceptions of fairness of opportunity or career progression. Similarly, there are improvements nationally in the fairness of treatment of staff involved in incidents.

Next steps

Much of the work the Trust embarked upon over the past year to improve staff experience needs to be sustained over the long term to make a difference. The Trust-wide action plan is largely therefore a reinforcement of actions that are already in train, though renewed energy is needed to ensure they start delivering tangible results.

Now that the new borough-based clinical operational structure is well-established, the new directorates are being asked to develop and implement targeted local action plans to complement and reinforce this Trust-wide plan. These will be shared in due course.

Workforce Race Equality Standard

Below outlines the percentage of staff experiencing harassment, bullying or abuse from staff in 12 months.

White	Trust score 2017: 23%	Trust score 2018: 25%
BME	Trust Score 2017: 26%	Trust Score 2018: 31.6%

Fig. 19: Percentage of staff experiencing harassment, bullying or abuse from staff in 12 months.

Our workforce is our most valuable asset and it is imperative that all staff feel valued, supported and engaged in order to provide the highest quality of service. Feedback from the Staff Survey and the BME Network indicates that the experiences by our BME staff are reported as less positive. Diversity and inclusion are core to the delivery of good high quality services by motivated and engaged staff.

The WRES Implementation Plan Year 1 and Year 2 are aimed at continuing to develop the foundations for change for equality and inclusion within the Trust, especially for BME staff where their reported experience is less favourable than white staff. This report identifies the difference in experience between white and BME staff and applicants through the 9 different WRES standards including Board composition and the proportional ethnicity of staff across the different pay scales and bandings. Four standards are taken from the Annual Staff Survey.

The first 9 months of Year 1 of the WRES Implementation Plan has provided useful learning with a range of degrees of progress. The Snowy White Peaks Group's reflection is that the components of the plan largely remain valid however there is a need in Year 2 to become much more focused in ensuring full implementation in all parts of the Trust and in obtaining detailed monitoring and more contemporaneous data that will enable Operational Directorates and Corporate Directorates to spot issues as they arise and adjust their plans and behaviours accordingly.

To remind ourselves, the Board's 3 Aspirations approved at its May 2017 meeting are that there will be proportionate numbers of BME staff

- Across all senior grades
- Within disciplinary processes
- Accessing career development opportunities

We are continuing with implementing the Action Plan which will include a further phase of the inclusive leadership organisational intervention, the development and implementation of a mentoring programme, ongoing monitoring of recruitment success and referral to formal disciplinary process and additional training of Diversity in Recruitment Champions to participate in recruitment to senior roles within the Trust.

Freedom to Speak Up Guardian

2018/19 has been a busy year for FTSU in the Trust. As the statistics show in the Board reports, we have seen an increasing number of cases being raised and a growing recognition of the function across the Trust.

The National Guardian's Office [NGO] declared October 2018 to be a national Freedom to Speak Up month and the Trust fully participated. Many activities were carried out across the Trust to increase staff awareness of the function. This was reported in detail at a presentation to the Board at the end of October. As a result of the activity 3 new Advocates came forward to join the FTSU Network and cases jumped from 9 in Q2 to 19 in Q3.

The CQC in August 2018 scrutinised the FTSU function as part of the Well Led Inspection. They identified 3 "should do's" about the need to continue to promote the function so that every member of staff is aware of it; to ensure there is clear open recruitment to the role of Advocate; and to continue to train and develop the Advocates. A report to the Delivery Board in February 2019 has demonstrated satisfactory progress on all 3 fronts.

Preparation is underway for the Board to undertake a self-review against the Guidance for Boards on Freedom to Speak Up in NHS Foundation Trusts. The response to the Guidance was reported to the Board by the Chief Executive in October 2018 and the Self-Review exercise will take place in May 2019.

The second Annual Report of the Freedom to Speak Up Guardian will be presented to the Board in April 2019 with quarterly reports to the Board from the FTSUG for the rest of the year. This report will analyse the cases for 2018/19, reported quarterly to the NGO, identifying themes and barriers to speaking up as well as learning and improvement opportunities.

Equality information and objectives

The Trust has a longstanding commitment to demonstrating accountability for its performance on promoting equality within its workforce and service provision. The Trust publishes a suite of annual equality information to demonstrate how it complies with its equality obligations. This includes the following:

- 2018 Workforce equality information: This provides equality data for staff with different protected characteristics on a range of workforce metrics.
- 2018 Trust-wide equality information: This provides information on the demographic profile of the Trust's service users and the experience of service users from all protected characteristics during the previous three years
- 2018 ethnicity reports for Croydon, Lambeth, Lewisham and Southwark: These provide ethnicity access and experience ethnicity data on key services in each borough. This year's report also includes outcome data for Improving
- Workforce Race Equality Standard (WRES) information
- Annual gender pay gap report.

The Trust's equality objectives are set out in our Integrated Equalities Action Plan 2018-21. It aligns the Trust's approach to promoting equality for its workforce and for service users, carers, families and communities and reflects the strategic priorities of the Trust's 'Changing Lives Strategy'. It captures existing commitments, legal requirements, prioritised areas for improvement and sets out measures of success over the next three years.

From this year the Board will receive an integrated annual report on action plan delivery, equality information and a refreshed Equality Delivery System (EDS 2) assessment in June. This alignment will provide the Board with an efficient and effective view of implementation and outcomes of all work streams in the Integrated Equalities Action Plan. It will also enable the Trust to be more focussed and responsive to the equality information it publishes each year.

Part 3: Priorities for improvement and statements of assurance from the Trust Board

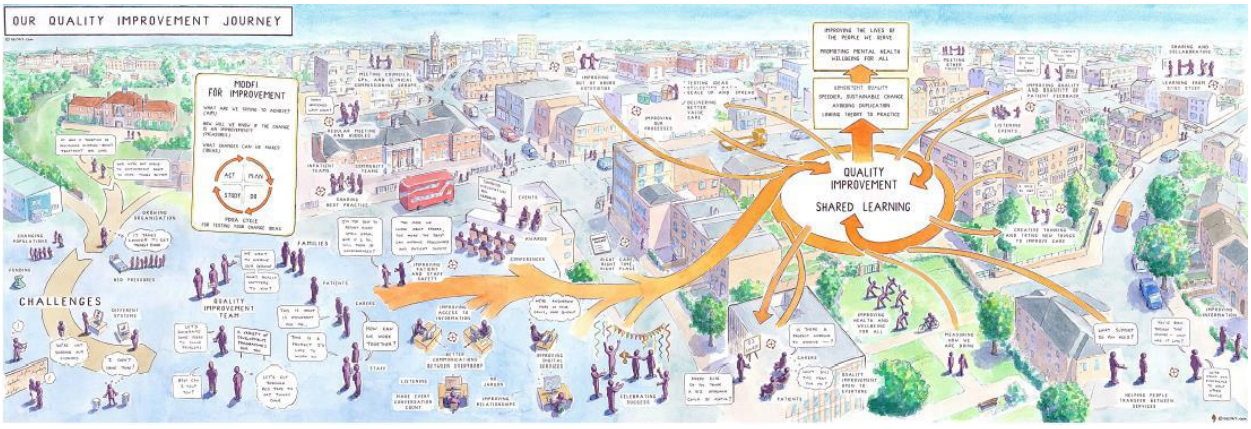
Our priorities for improvement for 2019/2020

The priorities for 2019/2020 have rolled over from 2018/2019 and remain arranged under the four areas outlined below which incorporate the broader domains of patient safety, clinical effectiveness, patient experience and staff experience. It was agreed to set the priorities over a three year stretch target to enable QI programme and relevant work streams to embed and sustain real improvement. Achievement relating to these priorities will be reported in next year's Quality Accounts.

- **We will reduce violence by 50% over three years with the aim of reducing all types of restrictive practices**
- **All patients will have access to the right care at the right time in the appropriate setting**
- **Within three years we will routinely involve service users and carers in: service design, improvement, governance and the planning and delivery of their loved one's care.**
- **Over the next three years we will enable staff to experience improved satisfaction and joy at work**

Fig. 20: Percentage of staff experiencing harassment, bullying or abuse from staff in 12 months.

Quality Improvement (QI)



Instrumental in achieving the Trust Quality priorities is the QI methodology underpinning the many improvement work streams within the Trust, the main trust wide ones are outlined below:

Improving Care and Outcomes (ICare) with general adult mental health inpatient and community services

Introduction and background

ICare is a trust wide Quality Improvement (QI) programme within the general adult care pathway (inpatient and community). It was set up in May 2017 with support from the Institute for Health Care Improvement (IHI), in response to problems that were highlighted with inconsistency in the quality of care and outcomes for people who use SLaM services. Whilst there were some areas of excellent practice, others required improvement. Too many patients are admitted outside of their local borough, significant variation in hospital length of stay was highlighted; with some significant delays in some areas, and teams were not always working at their best across boundaries with teams in other CAGs and with primary and social care.

The IHI quality improvement collaborative methodology was adopted as an approach. This provides an opportunity for the four boroughs to work together to develop and improve a consistent approach to care (access, safety experience) and outcomes.

Seven key principles, developed collaboratively underpin the approach, namely that Icare improvement work would:

1. Have clear sponsorship and leadership from senior clinicians and managers
2. Be co designed or co-produced with patients being at the centre and involve carers, staff and external stakeholders
3. Make systematic use of data to inform and test and change ideas for improvement
4. Ensure service users and staff feel are physically and psychologically safe to use and work in services
5. Provide opportunities for people to develop their knowledge and skills in QI methodology to enable them to test changes, share learning and scale up and spread successes.
6. Be supported by the Quality improvement and SLaM Partners (QISP) team, who have expertise in QI methodology (methods, tools, measurement, value) and psychological approaches to organisational development
7. Governed through weekly Icare meetings

Patient Safety

There are a range of initiatives being tested to improve the safety of our inpatient units. ICare has focussed on Four Steps to Safety and latterly the testing of behaviour support plans.

Four Steps to Safety

Four Steps to Safety was initially launched in January 2016 and involved an extensive suite of interventions to reduce violence and aggression. This is a trust wide initiative and for adult mental health this work has been incorporated into ICare. Between January – April 2018, the QI Team facilitated a review of the work across each CAG, identifying the challenges and what had worked well. The findings were presented at an Inpatient Safety Learning event in May 2018. As a result, the initiative was relaunched with fewer interventions:

- DASA: A risk assessment tool used to identify and communicate the likelihood of violence and aggression over a very short period of time, prompting staff to provide support earlier to prevent incidents from escalating.
- Report-out board: A visual tool used to update the team of specific tasks and who in the team is responsible for which task, to help ensure people's needs are being met.

- Proactive engagement: 'Checking-in' conversations with patients during each shift to identify and act on their needs promptly.
- Mutual agreement: A document coproduced with patients and staff around the values and shared expectations of how people will behave towards each other.
- SBARD (**S**ituation, **B**ackground, **A**ssessment, **R**ecommendation, **D**ecision): A communication tool used for clinical handovers to ensure the concise communication of pertinent information.

Successes and challenges

The QI Team have worked alongside the Modern Matrons in adult mental health to support the acute wards to implement the Four Steps to Safety. There are pockets of success where wards have fully implemented the interventions and are demonstrating improvements. However, we have not yet reached the target of a reduction by 50% by refreshing the programme as highlighted above, we are hopeful of nearing the quality priority target.

Standardised ways of working

We want to ensure that the people who access our services experience the same standards of care no matter which borough they live in or which service they are under. Both the inpatient and community operational care process models (CPM) are being developed with service users, carers and staff so that people know the fundamental standards of care, namely standards of best practice (SBP), they can expect to receive in every ward and community team. The theory is that if we have SPB that these will reduce variation in practice and have a positive impact on patients receiving timely assessments and treatment thereby reducing need for admission, improving experience and achieving outcomes that matter to them. The operational standards for the SBP in the models below, have been developed in the context of Royal College of Psychiatrists' Standards and learning from other mental health Trusts, Trust polices for good practice and national guidance. Furthermore, it has been informed and developed using Trust data and the outputs of the detailed care process maps produced with clinicians, service users and carers.

The aim therefore is:

For inpatient CPM that:

The patient experience and recovery journey is structured, purposeful, collaborative, safe and compassionate, taking into account complex needs and harm minimisation.

For the community CPM that:

Together with partners provide the community with easy access to the right mental health services, of the right quality, for the right length of time that meets their needs

We will measure whether the inpatient and community CPMs contribute to making a difference to outcomes using the agreed set of outcome and process measures for ICare, including length of stay, number of admissions, readmissions with 30 days, adherence to SBP, patient experience and staff engagement and cost. Local and more specific ward/community improvement measures will be used in addition and will be determined based on the needs of local teams.

Care Quality Commission (CQC); inspection July 2018 results and actions

The Trust is required to be registered with the CQC and its current registration status is registered, without condition. In 2018 SLaM participated in a Well Led review of the Trust as well as a CQC inspection of the following services outlined in the table below:

Pathway
Acute wards for adults of working age and Psychiatric intensive care units
Community- based mental health services for older people
Forensic Inpatient/Secure wards
Mental health crisis services and health based paces of safety
Specialist Services- Eating Disorders
Specialist Services- Lishman Unit

Fig. 21: Services inspected by CQC in 2018.

Whilst the overall rating for the Trust remains the same at 'Good' the Trust received a regulation 29A (HSCA) Warning notice for the Acute and PICU pathway.

The Trust was asked to make improvements by the 1st April 2019 and ensured an appropriate action plan was brought in place which would build on the many actions that were already underway as a part of borough reorganisation. Following receipt of the Warning Improvement Notice the Trust Senior Management Team set about engaging with Trust Executive to develop a robust and achievable improvement plan.

These discussions resulted in the following priority areas for improvement:

(i) Fundamental standards of care
(ii) Governance
(iii) Leadership and culture
(iv) Clinical pathways including flow and discharge planning.

There was also a clear focus on ensuring that there is the right infrastructure in place (enablers) to support these improvements and a clear structure for engaging and communicating with staff (communication), service users and carers.

The CQC re-inspected the Trust in April 2019 and initial verbal feedback indicates there has been significant improvement and the warning notice is no longer in place.

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 Inquiries that SLaM was eligible to participate in during 2018/19 are listed below:

- Four national Prescribing Observatory for Mental Health (POMH-UK) audits:
  - Valproate prescribing in bipolar illness
  - Use of antipsychotic long-acting injections for relapse prevention
  - Use of Clozapine
  - Rapid tranquilisation
- Commissioning for Quality and Innovation (CQUIN) 2017/18 Indicator 3a: Improving Physical Healthcare to Reduce Premature Mortality in People with Severe Mental Illness (SMI)
- National Audit of Care at the End of Life
- National Clinical Audit of Anxiety & Depression
- National Clinical Audit of Anxiety and Depression – Psychological Therapies Spotlight Audit
- National Clinical Audit of Psychosis – EIP Spotlight Audit

The reports available to the provider in 2018/2019 were reviewed and SLaM intends to take the following actions to improve the quality of healthcare provided.

National Audit	Key actions
CQUIN Indicator 3a: Improving Physical Healthcare to Reduce Premature Mortality in People with Severe Mental Illness (SMI)	Develop strategy to improve communication with GP mental health leads. Physical Health Improvement and Implementation Leads to review and develop pathways to ensure appropriate physical health interventions are offered/received.
National Audit of Care at the End of Life	Report not yet available
National Clinical Audit of Anxiety & Depression	Report not yet available
National Clinical Audit of Anxiety and Depression – Psychological Therapies Spotlight Audit	Report not yet available
National Clinical Audit of Psychosis	Please see Fig. 24 below

Fig. 23: Participation in national quality improvement programmes

NCAP 2018

In general performance was around the national average. Notable findings include:

- Monitoring of most physical health risk factors was above the national average.
- Prescribing practice was above average but provision of information to patients was below average in some respects.
- Availability of psychological therapies appeared to be above the national average.

Detailed recommendations are detailed in the table below, which Trust Leads will take forward.

Recommendation topic	Detailed recommendation	NICE Guidance
Physical health monitoring	Have at least an annual assessment of cardiovascular risk (using the current version of Q-Risk)	NICE CG181, 1.1.8
	Receive appropriate interventions informed by the results of the intervention	

	Have the results of this assessment and the details of the interventions offered recorded in their case record	
Psychological therapies and family interventions	Deploying sufficient numbers of trained staff who can deliver these interventions	NICE CG178, 1.4.4.1
	Making sure that staff and clinical teams are aware of how and when to refer people for these treatments	
Provision of written information	Are given written or online information about the anti-psychotic medication they are prescribed	NICE CG178, 1.3.5.1
	Are involved in the prescribing decision, including having a documented discussion about benefits and adverse effects of the medication.	
Employment and training opportunities	Ensure that all people with psychosis who are unable to attend mainstream education training or work are offered alternative educational activities according to their individual needs; and that interventions offered are documented in their care plan	NICE CG178, 1.5.8.1
Annual summary of care	An annual summary of care should be recorded for each patient in the digital care record. This should include information on medication history, therapies offered and PH monitoring/interventions; be updated annually; be shared with the patient and their primary care team.	N/A
Use of data in conjunction with NHS digital	NHS Digital, NWIS, Commissioners, Trusts and Health Boards should work together to put in place key indicators for which data can easily be collected, perhaps using an Annual summary of care (see rec 5). This work should be informed by the NCAP results and the experience of the NCAP team.	N/A

Fig. 24: NCAP recommendations 2018

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 submitted data for the 2018-19 POMH-UK audits, as required. Below is a summary of the findings from those audits. SLAM is trust 022 and TNS is the total national sample.

Use of antipsychotic long-acting injections for relapse prevention

This survey assessed adherence with certain recommendations in the NICE guideline for the management of psychosis and schizophrenia in adults. SLAM submitted data for a random sample of community patients.

Overall, a higher proportion of patients in SLAM had evidence of the assessment of side effects of a depot, as shown below.

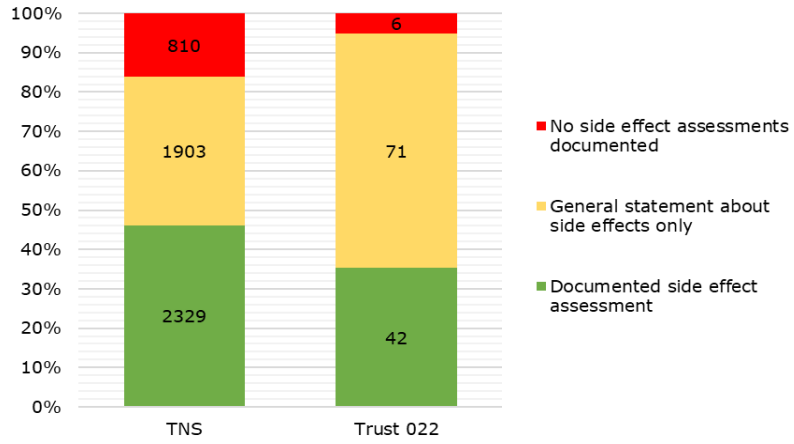


Fig. 25: POMH - Use of antipsychotic long-acting injections for relapse prevention

A similar proportion of patients in SLAM and the average national sample had received a medication review within the previous year and had a clinical plan documented in their notes for the management of non-adherence with a depot, as shown below.

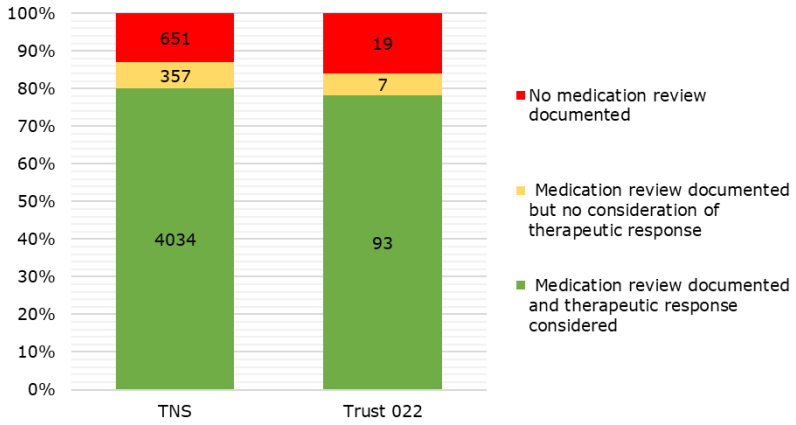


Fig. 26: POMH - Use of antipsychotic long-acting injections for relapse prevention

A similar proportion of patients in SLAM and the average national sample had a clinical plan documented in their notes for the management of non-adherence with a depot, as shown below.

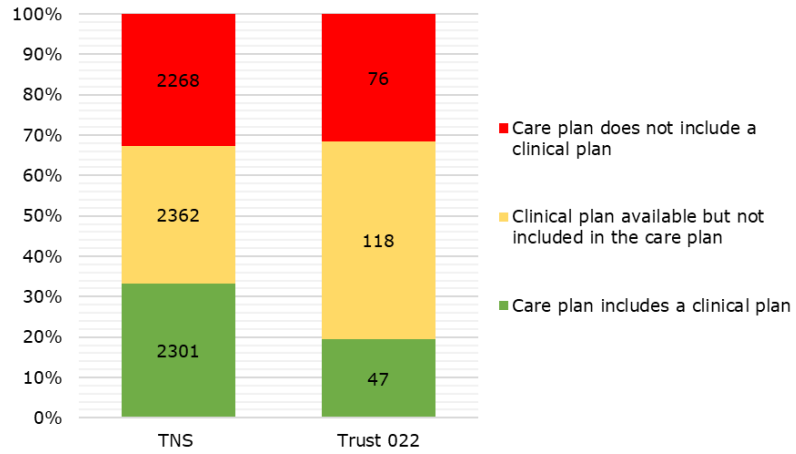


Fig. 27: POMH - Use of antipsychotic long-acting injections for relapse prevention

Actions: Clinicians have been informed of results and recommendations.

POMH – valproate prescribing in bipolar illness

Valproate should not routinely be prescribed for women of childbearing age. All patients prescribed valproate should have an annual physical health check. In 2017 the trust participated in the re-audit of valproate use in bipolar disorder. Results were reported in 2018.

Overall, more patients had evidence of physical health monitoring in SLAM compared with the average national sample, as shown below.

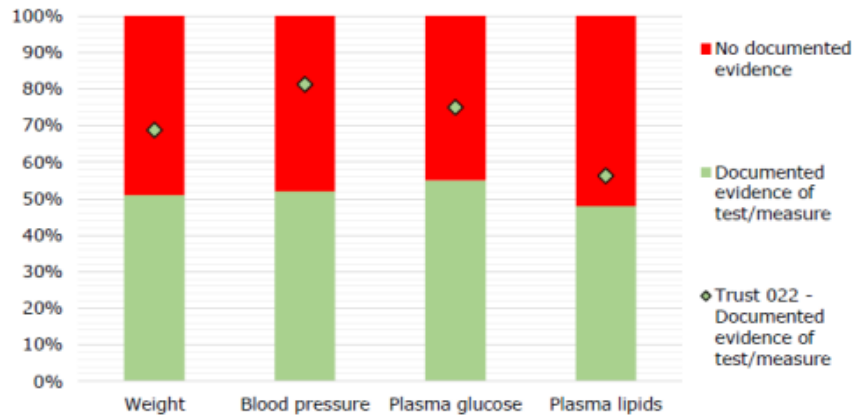


Fig. 28: POMH - valproate prescribing in bipolar illness

Fewer women of childbearing age were prescribed valproate in SLAM compared with the average national sample, as shown below.

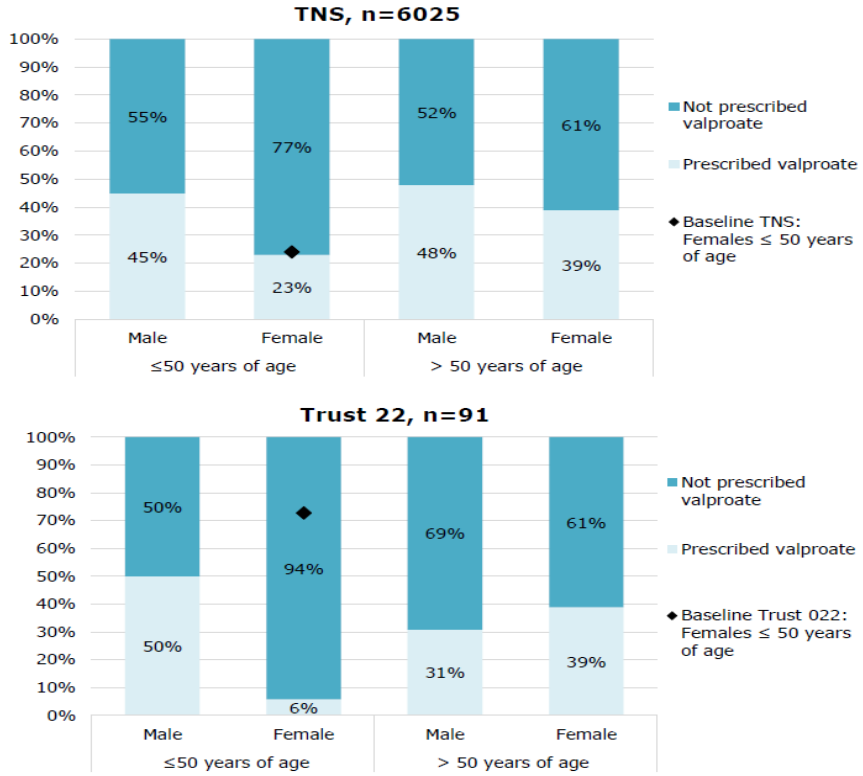


Fig. 29: POMH - valproate prescribing in bipolar illness

Actions: Clinicians have been informed of the results. In addition, clinicians have been informed of the MHRA requirements for valproate use in women of childbearing age. When supplying valproate to pharmacy checks that the women of childbearing age have been enrolled in the pregnancy prevention programme (PPP) and that they are given information about teratogenic potential of valproate. Prescribers are informed of any women who have not been enrolled in the PPP.

POMH – Rapid tranquilisation (RT)

Data were collected in March 2018.

Overall, no patients were administered IM haloperidol, which is in line with SLAM RT policy. Monitoring of physical and mental health after RT was evident for fewer patients in SLAM than in the average national sample (as shown below)

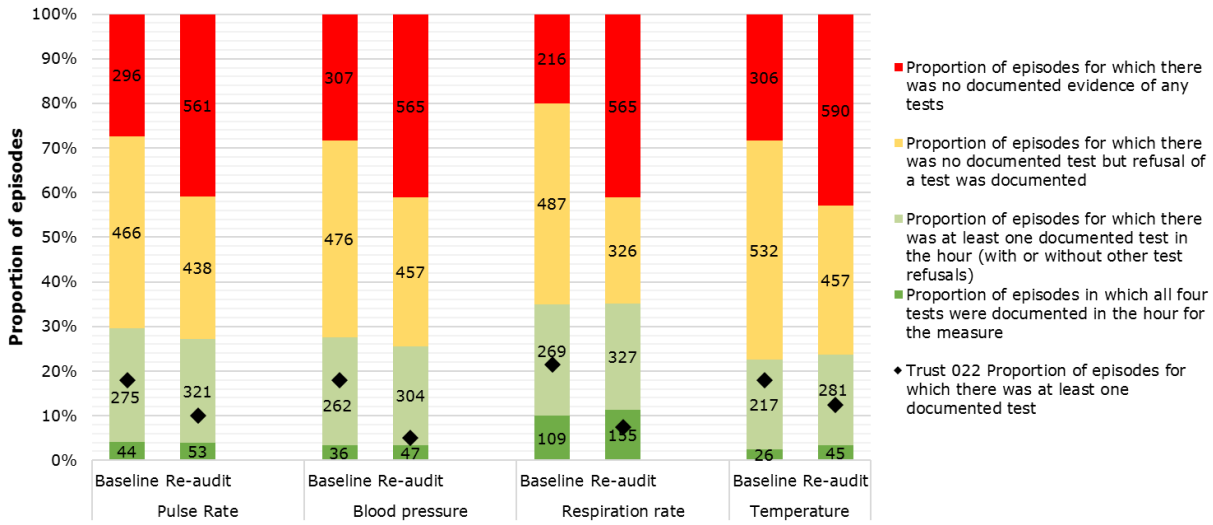


Fig. 30: POMH – Rapid Tranquilisation

Actions: The RT policy has been updated to include the updated physical health monitoring requirements after RT. The trust has provided training on physical health monitoring after RT. Individual incidents of RT are identified each week from prescription charts by pharmacy and followed up by the nursing team to ensure physical health monitoring was completed.

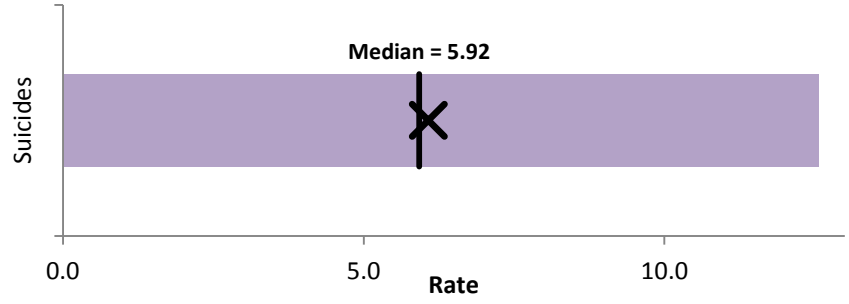
Use of clozapine

Data have been submitted. Awaiting report

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

The Trust participated in the NCISH which reviews data relating to people who have died by suicide or were convicted of homicide based on the most recent available figures (2014-2016).

The figure below gives the range of results for mental health providers across England, based on the most recent available figures for suicides (2014-16). 'X' marks the position of the Trust. Rates have been rounded to the nearest 1 decimal place and percentages to whole percentage numbers.



Suicide rate

The suicide rate was 6.08 (per 10,000 people under mental health care) between 2014-16.

Fig. 31: Suicide Rate (2014-2016)

The Trust is implementing a new suicide project group on 09th May 2019 which will look at the implementation zero suicide strategy which will report into the mortality review group.

Trust Clinical Audit Programme

Audit	Status	Summary	Outcomes
Care Plan and Risk Assessment - Inpatient and Community Monthly	Complete	To monitor ongoing care plan and risk assessment documentation.	There is good documentation of issues being identified in care plans, as well as support and intervention plans to address identified needs. Most care plans are written in ways which will be understood by service users and carers. There is good documentation with regards to risk domains being identified accurately. Care Plan and Risk Assessments are reviewed monthly at Performance and Quality meetings. Service Directors will be supported to deliver improvements.
QuESTT – Inpatient Monthly	Complete	The Quality, Effectiveness and Safety Trigger Tool (QuESTT) is completed by inpatient wards on a monthly basis. It is a safety trigger tool developed so individual wards can anticipate where standards may start to deteriorate and therefore act to prevent care failures occurring.	Action plans for wards scoring Red, Blue and Amber have been formulated in a timely manner to address concerns highlighted in the relevant month's QuESTT tool. Services continue to experience unusual demand and high acuity on some of the units which is being monitored. Vacancies and supervision compliance also being monitored. QuESTT scores are reviewed monthly at Performance and Quality meetings. Where wards score Red, Blue or Amber, action plans are recorded onto Datix for review and implementation. Immediate action is taken at the time of the audit with concerns/increasing risk and escalated.
Policy	Complete	The audit was undertaken to assess policy documentation across the Trust and identify and determine whether policies adhered to the Trust Policy for the Development and Management of Trust wide Policies. The audit followed changes in the clinical policy process carried out by the Clinical Policy Working Group (CPWG). All policies (179) publicised on the Trust intranet, from 25th October 2017 to 28th February 2018, were included within the audit.	A summary was brought to the attention of the Operational SMT and Policy leads were made aware of any overdue policies. An ongoing outcome is that the standard of policies are monitored and reviewed within the Clinical Policy Working Group according to the agreed checklist.
Duty of Candour	Complete	The audit was undertaken to assess ongoing compliance with the Being Open and Duty of Candour policy (2018) and to review the action plan from the 2017 audit. A sample of 80 serious incidents was randomly extracted from the Datix incident reporting system spread across a period of twenty months up to June 2018. The sample was split equally between Serious Incident Requiring Investigation (SIRI) and Serious Incidents (SIs).	The audit demonstrated high levels of compliance for SIRIs, but overall lower levels for C grade incidents which met the criteria for Duty of Candour. The recommendation from this audit was to continue to implement the comprehensive action plan that was derived following the 2017 audit.

Engagement and Observation	Complete	The audit highlighted that while there was evidence of positive engagement with service users and observations were carried out correctly there still needed to be an improvement in documentation of these events. The audit involved four different approaches; incident analysis, service user questionnaire, daytime monitoring of interactions on the wards and night time monitoring too.	Compared to the 2015 audit, there is a significant improvement in observations of service users of the highest level of risk however overall compliance around record keeping for intermittent observations was generally low across most standards and require improvement. This includes documentation of decision making, risk assessments and care planning. Audit results are informing the Engagement and Observations policy review currently underway.
Domestic Abuse	Complete	The audit aimed to assess awareness, knowledge and understanding of domestic violence among clinical staff. An electronic survey was emailed to all clinical staff and included questions regarding their attitudes and identification processes, and knowledge. A total of 167 responses were returned.	Staff reported that they feel confident in asking questions about domestic violence and documenting risks and history on EPJS. 20% increase in the number of staff reporting they knew who their borough MARAC representative is. Required improvements identified regarding staff awareness and in staff reporting they felt confident in conducting a safety assessment for children. A re-audit is planned for 2019. Trust safeguarding Lead and safeguarding children advisors to look at the current training package to ensure that the current slides reflect domestic abuse and the impact on children. Trust Safeguarding adult lead will provide an update on guidance offered in the recent intercollegiate adult safeguarding document in relation to domestic abuse.
Safeguarding Children	Complete	The audit is designed to assess the current compliance with the Safeguarding Children Policy Principles and Procedures (2014). A random sample of 150 cases was selected where children were identified in the child risk screen in a minimum of 50 cases. The sample of 150 was distributed between 13 Safeguarding Children leads for data collection. Data was collected from 1st June 2018 to 20th July 2018.	Whilst compliance was generally high there were some standards which needed improving. Recommendations in light of this audit include informing or reminding staff about timelines of completion and appropriate review of child need risk screens.
Supervision	Complete	The Supervision Audit assessed the current compliance with the Supervision Policy V5 (2018) standards for the Quality of Supervision. The Supervision Audit is a Trust-wide review of the quality of supervision as it has been experienced by all staff groups, not limited to clinical staff. An online survey was circulated to all staff.	There was an increase of 3% in staff receiving supervision compared with the 2013 audit. There was high compliance relating to supervision enabling staff to do their jobs better, feeling valued and able to raise concerns, although the former two questions did decrease on 2013 results.

Section 132 - Inpatient and Community Treatment Order	Complete	The audit assessed whether patients detained under the Mental Health Act (MHA) or subject to a Community Treatment Order (S17A/CTO) are informed of their statutory rights via the S132/132A and whether rights are repeated as required by policy.	The standards audited indicated that policy is being adhered to, however there is room for improvement. As such, recommendations in light of this audit include the reissuing of a Blue Light Bulletin to emphasise the importance of improved compliance with S132, the issue of a Purple Light Bulletin, updates of the weekly MHA monitoring tables, continuation of a QI project to improve compliance at ward level and a re-audit in 12 months to check compliance.
Central Alerting System	Complete	The audit assessed compliance with reporting, actioning and maintaining evidence logs.	For reportable alerts, 100% compliance was confirmed for reporting, actioning and maintaining evidence logs. However, a lack of a formal system for logging drug alerts and non-reportable alerts was identified. Formal logging systems for drug alerts and non-reportable alerts have been implemented and governance arrangements formalised with compliance reporting and annual reports. The policy has been updated.

Fig. 32: Trust clinical audit programme (2018/19)

Patients participating in research

The number of patients receiving NHS services provided or sub-contracted by SLaM for the reporting period, 1 April 2018 – 31 March 2019, that were recruited during that period to participate in research approved by a research ethics committee was 3,578.

SLaM research is having an impact in many areas including:

- **Developing novel treatments:** e.g. Trials of Cannabidiol (CBD) for psychosis.
- **Influencing health policy:** e.g. Enhancing treatment guidelines for depression
- **Improving services based on our research evidence:** e.g. First episode service for eating disorders (FREED)

More information can be found here: https://www.kcl.ac.uk/ioppn/research/agenda.aspx

Commissioning for Quality and Innovation (CQUIN)

As last year, 2.5% of SLaM income 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 2018/19 was £6.0m and at the time of writing the Trust is collating quarter four reports for submission to our commissioners.

Hospital Episode Statistics Data – HES

SLaM submitted records during 2018/19 to the Secondary Uses services (SUS) 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 -Dec 2018	Out-patients and Community – Mental Health Monthly Data Set (MHMDS) Nov 2018 (Final)
NHS No	98.1%	99.1%
GP Practice code	98.9%	98.3%

Fig. 33: Percentage of records relating to patient care which included the patient's NHS No and GP practice code.

Information Governance

Our submission for the NHS Digital Information Governance (IG) Toolkit 2017-18 demonstrated 90% compliance, which is satisfactory compliance. The submission was independently assessed by internal audit with a substantial assurance outcome.

The Trust Digital Services are continuing to lead the digital transformation programme. The IG Operating Model has been implemented to further improvements around IG compliance with national standards and key legislation whilst implementing the trust's Digital Strategy.

The Trust undertook the General Data Protection Regulations (GDPR) preparedness programme overseen by the Information Security Committee (ISC). The ISC is also overseeing the Cyber Security Programme with close engagement and independent reviews by NHS Digital's careCERT and careCERT Assure Programmes. The trust has undertaken an extensive review of all data assets and data flows undertaking data protection impact assessments. All trust policies have been updated in line with the Data Protection Act 2018 and an updated Privacy Notice to notify service users and the public published. The Trust appointed a Data Protection Officer to oversee compliance and has set up the SE London DPO Forum to enable knowledge exchange and regional compliance between the DPOs.

SLaM refreshed NHS Digital's SCCI1596 Secure Email Standard conformance and @slam.nhs.uk continues to be accredited as a secure email system since 30 September 2017.

The Trust has worked with regional partners to sign up to a single, consistent, clear and unified data sharing framework across SE London. This has led to further expansion of the shared care record with the successful implementation of the Virtual Care Record (VCR).

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

Assurance around IG is presented to relevant committees chaired by the Caldicott Guardian, the CCIO and the Chief Information Officer (the Senior Information Risk Officer). The Trust Senior Management and the Board receives regular updates on levels of data assurance.

Payment by Results Clinical Coding

SLaM is not subject to a Payment by Results Clinical Coding audit as it has not provided acute hospital services during the 2018/2019 financial year. Mental health services have a different payment approach which includes mental health care clusters. Our clinical information system has built in alerts to remind clinicians that a mental health cluster has expired which promotes data capture.

We see high quality data as key to informing the provision of high-quality care, both at an individual patient level and in terms of commissioning services for our local populations.

Currently we recognise that, like many NHS organisations, we have challenges with both the consistency and accuracy of data across our systems, and ensuring this data is used in a meaningful way to drive improvements in our services.

Last year we started our data framework project to address these issues, specifically to develop an online automated Trust dashboard so that all staff can access data to make better data informed decisions. As part of this on-going project we have been addressing the issue of data quality through our weekly project meetings, looking at how, where and by whom data is entered, and how that data is integrated across our systems and subsequently presented back to staff in a way that is useful.

Our series of data summits 'Operation SOS: Solving our Systems' brought together our data system owners to collaboratively address these issues, and meanwhile work has continued to develop a new user interface for our electronic health record ePJS (launch April 2019) that will make accurate, timely and complete data entry easier for staff.

Over the course of the coming year we will continue to build on our data quality work, through development of our informatics strategy, system architecture and the establishment of the Trust's new Quality Centre, which will see intelligent, high quality data use as central to improvements across our system for the benefit of all our patients, carers and staff.

National indicators 2018/2019

SLaM is required to report performance against the following indicators:

- Care Programme Approach (CPA) 7 day follow-up
- Access to Crisis Resolution Home Treatment (Home Treatment Team Gatekeeping)
- Re-admission to hospital within 28 days of discharge

National indicators 2019/2020

SLaM is required to report performance against the following indicators:

- Care Programme Approach (CPA) 7 day follow-up
- Access to Crisis Resolution Home Treatment (Home Treatment Team Gatekeeping)
- Re-admission to hospital within 28 days of discharge

Care Programme Approach (CPA) seven 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 2015/16	SLaM 2016/17	SLaM 2017/18	SLaM 2018/19	National Average 2017/18	Highest Trust % or Score 2017/18	Lowest Trust % Score 2017/18
Not specified (formerly 95%)	96.99%	**97.1%**	**97.5%**	**96%**	95.4% (Q3)	100%	69.2%

Fig. 34: CPA, seven day follow up

The lowest/highest and National Average scores (for a Trust) are based on the Q1-3 scores in 2017/18 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 2015/16	SLaM 2016/17	SLaM 2017/18	SLaM 2018/19	National Average 2017/18	Highest Trust % or Score 2017/18	Lowest Trust % Score 2017/18
Number of admissions to acute wards that were gate kept by the CRHT teams	95%	95.9%	**96.5%**	99.9%	**96.1%**	98.5 (Q3)	100%	84.3%

Fig. 35: 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: The Acute Referral Centre (ARC) is fully operational and all patients are triaged through this system.

Readmissions to hospital within 30 days of discharge for patients 0 – 15 years and 16+ years

Readmission within 30 days Standard measure is 30 days	SLaM 2018/19
Patients readmitted to hospital within 30 days of being discharged (0 – 15 years)	10.9%
Patients readmitted to hospital within 30 days of being discharged (16 years or over)	5.9%

Fig. 35: Readmissions to hospital for within 30 days by age group

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 2016/17 reports that the Trust had a 4% emergency readmission rate in comparison to a national mean of 9% 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 ongoing monitoring of the Adult mental health pathways, a redesign of our community provision and the implementation of QI initiatives.

Core indicators

The following indicators form part of appendices 1 and 3 of the Single Oversight Framework (SOF) published by NHS Improvement.

Indicator	SLaM 2018/19	National Target	National Target Met
1. Early intervention in psychosis (EIP): people experiencing a first episode of psychosis treated with a NICE-approved care package within two weeks of referral	74%	50%	✓
2. Improving access to psychological therapies (IAPT): proportion of people completing treatment who move to recovery	50.1%*	50%	✓
3. Improving access to psychological therapies (IAPT): patients seen within 6 weeks of referral	90.8%	75%	✓
4. Improving access to psychological therapies (IAPT): patients seen within 18 weeks of referral	99.3%	95%	✓

5. Care programme approach (CPA) follow-up: proportion of discharges from hospital followed up within seven days	96.1%	Not specified (formerly 95%)	✓
6. Admissions to adult facilities of patients under 16 years old	0	Not specified	✓
7. Inappropriate out-of-area placements for adult mental health services ***(This is a new requirement for 2017/2018 and reporting begins in Q4/18 which is broken monthly in the data presented.)***	Apr-18 – Feb-19 11,173 OBDs	Not specified	✓

Fig. 36: Core indicators

*The yearly average for indicator 2 for 2017/18 was 48per cent although by the end of the financial year the Trust had achieved a recovery rate of 52per cent

Indicators two, three and four are based on collated monthly internal Trust reporting, NHS Digital will publish full year performance later in 2019/20.

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.

Service Users Experience of Health and Social Care Staff Service Users Experience of Health and Social Care Staff

	SLaM 2017	SLaM 2018	Highest Trust Score 2018	Lowest Trust Score 2018
Service users experience of Health and Social Care Staff *Scores out of 10*	7.5	7.2	7.7	5.9

Fig. 37: 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 2018, 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 7.2 with other Trusts performing in a range of 5.9 to 7.7. The score for Q4 decreased by 0.2 points and Q5 increased by 0.1 points, although these changes are not categorised as significant shifts (changes of 5 points).

		SLaM 2018	Lowest trust score	Highest trust score	SLaM (n)	SLaM 2017	SLaM 2016	SLaM 2015	SLaM 2014
Health and social care workers									
S1	Section score	7.2	5.9	7.7		7.6			
Q4	Were you given enough time to discuss your needs and treatment?	7.3	6.2	8.0	176	7.5	7.3	7.6	8.0
Q5	Did the person or people you saw understand how your mental health needs affect other areas of your life?	7.1	5.7	7.5	168	7.0	7.1	7.1	7.8

Fig. 38: National survey of people who use community mental health services 2018

The trust continues to prioritise service user and carer involvement. Feedback regarding this is collected in a systematic way across the Trust, including through the local experience survey programme, PEDIC. This work is taken forward as part of the Patient and Public Involvement strategy and directorate improvement plans.

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 Q1-Q2 17/18	SLAM 17/18	Average for Mental Health Trusts	Highest Trust % or Score 17/18	Lowest Trust % or Score 17/18
Reported Incidents per 1000 bed days	=	51.5%	126.47 %	16%
Number of incidents resulting in severe harm	0.5%	0.3%	2.0%	0.0%
Number of incidents reported as deaths	0.2%	1.0%	3.8%	0.0%

NRLS Data Q1-Q2 18/19	SLAM 18/19	Average for Mental Health Trusts	Highest Trust % or Score 18/19	Lowest Trust % or Score 18/19

Reported Incidents per 1000 bed days	-	55.5	114.3	24.9
Percentage of incidents resulting in severe harm	0.2%	0.3%	2.1%	0.0%
Percentage of incidents reported as deaths	0.7%	0.9%	2.3%	0.1%

Fig. 39: NRLS (National Reporting and Learning Service) Data

Learning from Deaths

During 2018/19, 511 SLaM patients died. This is a reduction from 565 deaths in 2017/18. This comprised the following number of deaths which occurred in each quarter of that reporting period: 120 in the first quarter; 133 in the second quarter; 134 in the third quarter; 124 in the fourth quarter.

144 case record reviews and 62 investigations have been carried out in relation to 511 of the deaths.

In 23 cases, a death was subjected to both a case record review and an investigation. The number of deaths in each quarter for which a case record review or an investigation was carried out was:

Number of deaths where case record review or investigation was carried out	**Q1 2018/19**	**Q2 2018/19**	**Q3 2018/19**	**Q4 2018/19**
	29	36	47	94

Fig. 40: Number of deaths where case record review or investigation was carried out

Number of deaths reported in 2018/19 where case record review or investigations were carried out	**Total**
	CRR 144 SIRI 62

Fig. 41: Number of deaths reported in 2018/19 where the case record review or investigation was carried out in 2018/19

Our mortality reviews used adapted versions of two frameworks: the Mazars framework, and an adapted version of the grading system for case reviewers from the National Confidential Enquiry into Patient Outcome and Death (NCEPOD). Reviewers assess and grade the care provided to a patient using the two systems to assess and identify learning or a requirement for further review.

We have identified a number of learning points from case record reviews and investigations conducted in relation to the deaths identified above:

- The quality of risk assessments and care plans in some cases has been variable.
- Where care plans and risk management plans were completed these were not always individualised or specific enough.
- In PMOA there have been instances of referrals to the Memory Service that were either late, or the patient was too physically unwell.
- Mortality reviews have identified the need for improved physical health follow up in the community. This should include better links with primary care and better care planning.

Actions taken

The Trust has taken the following actions during 2018/19:

- In PMOA there is work underway with GPs to redesign the referral process and referral form.
- Older Adult have worked with CRISS to develop a tool to monitor antipsychotic monitoring for patient with dementia.
- Quality improvement projects to improve the waiting times for patients with a diagnosis of dementia have been ongoing; including increasing memory service capacity in Croydon.
- Up to date Information on community SALT services has been circulated to community teams.
- The inpatient nutrition screening tool is being redeveloped and that will include feeding / swallowing issues.

The Trust continues to assess the impact of the actions highlighted in mortality reviews.

In 2019/20 we will be implementing the Royal College of Psychiatrists' standardised care review tool for mental health services. The new care review tool will replace the existing mortality review tool in Datix. All deaths will be subject to completion of Section 1 of the review tool. Comprehensive mortality reviews (Section 2) will be triggered by Red Flags identified, or by random allocation of cases to be reviewed. The Red Flags included are:

- Family, carers or staff have raised concerns about the care provided.
- Diagnosis of psychosis or eating disorders during the last episode of care.
- Psychiatric inpatient at time of death, or discharged from inpatient care within the last month.
- Under Crisis Resolution and Home Treatment Team (or equivalent) at the time of death.
- Other locally determined criteria for review.

Directorates will be expected to randomly allocate 5% of all reported deaths for a mortality review. We are currently in the process of ratifying our mortality review policy and making changes to Datix. Directorates might decide on locally determined red flag criteria, and this will be presented and recorded in the Mortality Review Group meetings.

Duty of Candour 2017/2018

A number of actions have been taken during this year, including:

- A Duty of Candour information poster was produced April 2018.
- The Policy was revised in June 2018 including guidance for staff, template letters and external website reference.
- The Maud intranet site was updated regarding Duty of Candour in August 2018.
- The Serious Incident Review Group has continued to increase the scrutiny and oversight of Duty of Candour for serious incident investigations.

Further work that will be taking place in 2019/2020, including:

- Datix fields will be updated to help to improve Datix reporting.
- A QI project will be undertaken during 2019 to improve Datix reporting

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 Committee (QC) 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.

Annex 1

NHS Croydon CCG, NHS Lambeth CCG, NHS Lewisham CCG and NHS Southwark CCG Joint Statement on South London and Maudsley NHS Foundation Trust's Quality Account 2017/18
May 2018

Council of Governors' reply to Quality Accounts 2017/18

South London and Maudsley NHS Foundation Trust (SLaM) Quality Accounts 2017/18

Response from Healthwatch Southwark

Annex 2
Statement of Directors' Responsibilities In Respect of the Quality Report

Chair
South London and Maudsley NHS Foundation Trust

Dr Matthew Patrick
Chief Executive
South London and Maudsley NHS Foundation Trust

Glossary

Approved Mental Health Professionals (AMHP)	AMHPs are mental health professionals who have been approved by a local social services authority to carry out certain duties under the Mental Health Act. They are responsible for coordinating assessment and admission to hospitals.
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.
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 Care:** provides treatment and care to people who are experiencing a mental health crisis and need to be home treated or on occasion admitted to hospital. Acute Care services include 17 inpatient wards, 4 home treatment teams, 4 intensive care inpatient units, a 24 hour crisis line and centralised bed management services and a central place of safety service**.** **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 (see Dementia entry) or severe and complex mental health needs or under the age of 65 who develop dementia **Psychological Medicine and Integrated Care:** provides clinical care clinical care across mental and physical health through the General Hospital Liaison services with four acute hospitals. PMIC also provides services for people from around the country who need specialist care for eating disorders, perinatal problems, chronic fatigue syndrome, Neuropsychiatry, memory disorders, psychosexual conditions and HIV mental health. **Psychosis:** The largest CAG within SLaM provides services to adults experiencing Psychosis.
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.
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 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.
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 Health Minimum Data Set (MHMDS)	Mental Health Minimum Data Set (MHMDS) is a regular return of data from providers of NHS funded adult secondary mental health services, produced during in the course of delivering services to patients.
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 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.
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.

Fig. 40: Glossary