



**South London
and Maudsley**
NHS Foundation Trust

Quality Report 2018/2019

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Part 1: Statement on quality from our Chief Executive

It is my pleasure to introduce the 2018/19 Quality Report. The report is an important way for the Trust to communicate our commitment to improving the services we deliver to our service-users, their families, their carers and our local communities, and to report on progress with our Quality Priorities

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. Our staff, service users and Governors helped us to select our Quality Priorities.

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, and more recently the Long Term Plan. This year the Trust has received a 6.6% uplift across all 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.

South London and Maudsley NHS Foundation Trust (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 Institute of Psychiatry, Psychology and Neuroscience (IoPPN), Kings Health Partners (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.

We are committed to working with our partners to commission and deliver integrated health and social care at a neighbourhood and community level and we have progressed the development of our two alliance contracts, the Lambeth Living Well Network Alliance and Partnership Southwark.

As part of the Lambeth Alliance we are formal partners with Certitude, Lambeth Clinical Commissioning Group, Lambeth Council and Thames Reach. A key member of Partnership Southwark, we work alongside local GP federations and elements of Guy's and St Thomas' community services. We are continuing to work with partners to develop other population-scale contracts across both Lewisham and Croydon.

In 2018 we set Quality Priorities that are aspirational. This report is given at the end of year one. During the first year we have built the foundation from which to make change and as we go into the second year, in some areas, we are confident we are beginning to see positive change.

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 objectives in this area, including improved representation of BME staff in senior positions and improved career opportunities. Although disappointed in the survey results, we see them as an invitation to redouble our efforts and lead positive change. We are confident in our abilities in this regard.

In relation to the above, 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.

Signed



Dr Matthew Patrick

Chief Executive Officer
South London and Maudsley NHS Foundation Trust
Date: 23 May 2019

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, and 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; the overall rating is Good.

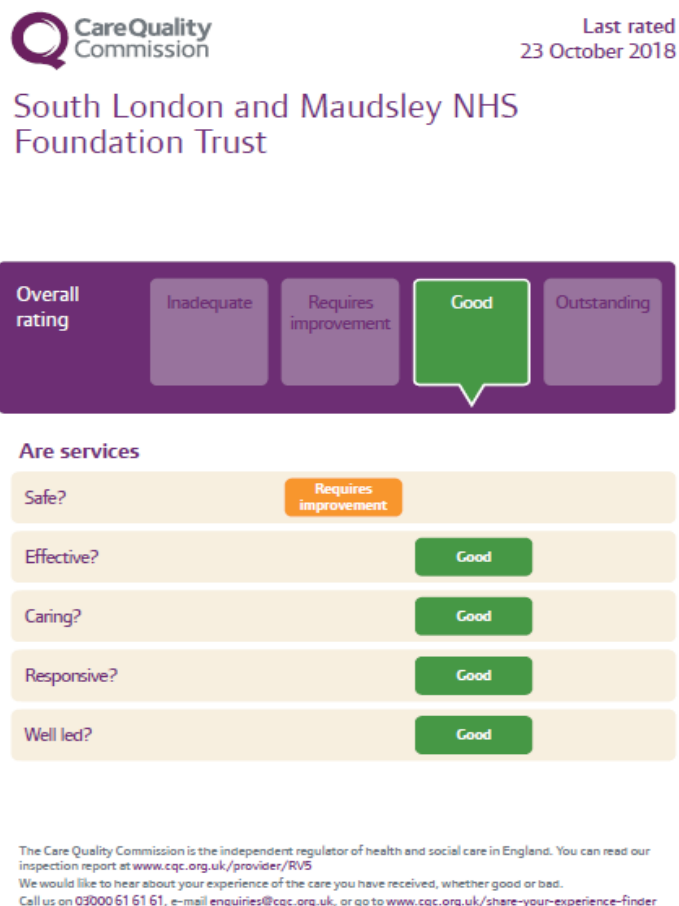


Fig. 5: Current trust CQC rating

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 are 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: Priorities for improvement and statements of assurances from the Board

Statements of assurance from the Board

During 2018/19, SLaM provided or subcontracted 233 NHS services including inpatient wards, outpatient and community services. As well as serving the communities of south London, we provide 53 specialist services for children and adults across the UK including perinatal services, eating disorders, psychosis and autism. We provide inpatient care for approximately 3,700 people each year and we treat more than 63,000 patients in the community in Lambeth, Southwark, Lewisham and Croydon, with a local population of 1.3 million with a rich diversity.

SLaM has reviewed all the data available to us on the quality of care in 233 of these NHS services.

- The income generated by the relevant health services reviewed in 2018/19 represents 100 per cent of the total income generated from the provision of relevant health services by SLaM for 2018/19.

Audits

Participation in national quality improvement programmes

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

During 2018/19, nine national clinical audits and one national confidential enquiry covered NHS services that SLaM provides.

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

The national clinical audits and national confidential enquiries that SLaM was eligible to participate in and did participate in during 2018/19 are as follows: [insert list].

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

The national clinical audits and national confidential enquires that SLAM participated in, and for which data collection was completed during 2018/19 are listed below alongside the number of cases submitted to each audit or enquiry as a percentage of the number of registered cases required by the terms of that audit or enquiry.

- Commissioning for Quality and Innovation (CQUIN) 2017/18 Indicator 3a: Improving Physical Healthcare to Reduce Premature Mortality in People with Severe Mental Illness (SMI) (n=150; 100%)
- National Audit of Care at the End of Life (N/A – site level responses required)
- National Clinical Audit of Anxiety & Depression (n=200; 100%)
- National Clinical Audit of Anxiety and Depression – Psychological Therapies Spotlight Audit (n=200; 100%)
- National Clinical Audit of Psychosis (n=200; 100%)
- National Confidential Inquiry into Suicide and Homicide by People with Mental Illness (NCISH) (N/A – Trust required to report every suicide and homicide incident; 100% compliance).

The reports of two national clinical audits were reviewed by the provider in 2018/19 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

National Clinical Audit of Psychosis (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	
	Deploying sufficient numbers of trained staff who can deliver these interventions	

Psychological therapies and family interventions	Making sure that staff and clinical teams are aware of how and when to refer people for these treatments	NICE CG178, 1.4.4.1
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.

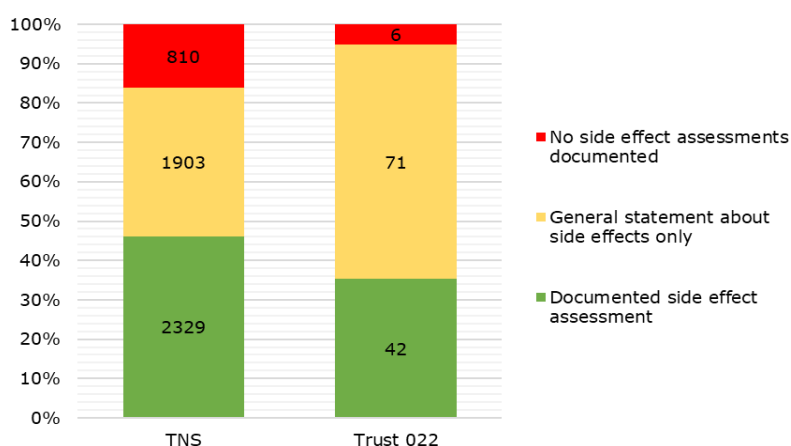


Fig. 25: POMH - Use of antipsychotic long-acting injections for relapse prevention

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.

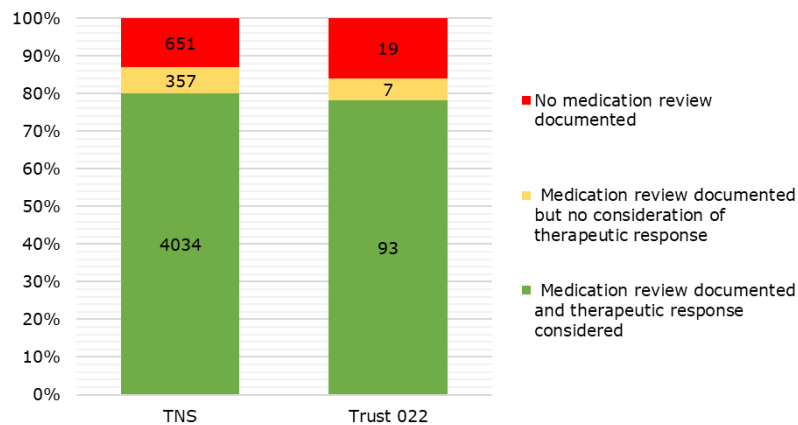


Fig. 26: POMH - Use of antipsychotic long-acting injections for relapse prevention

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.

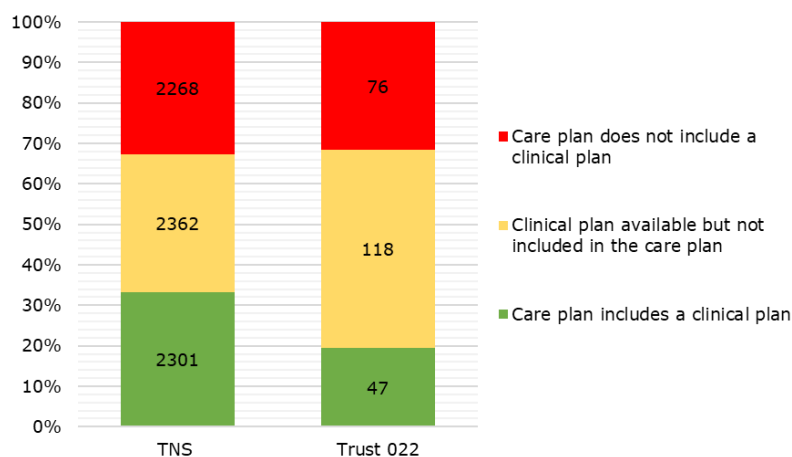


Fig. 27: POMH - Use of antipsychotic long-acting injections for relapse prevention

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.

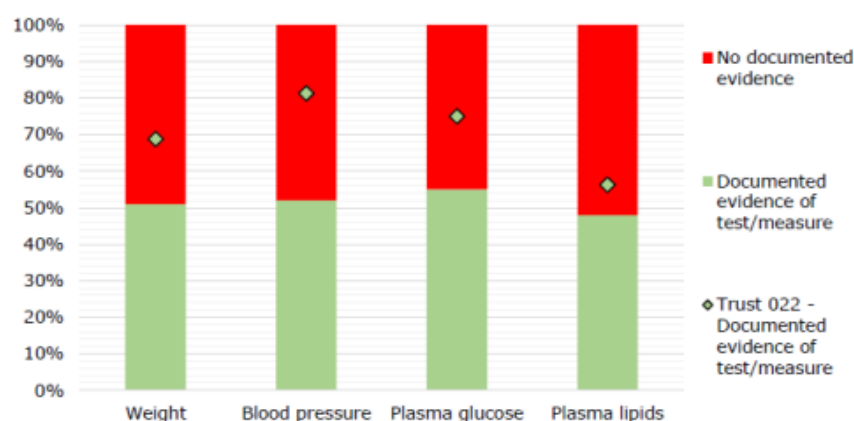


Fig. 28: POMH - valproate prescribing in bipolar illness

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

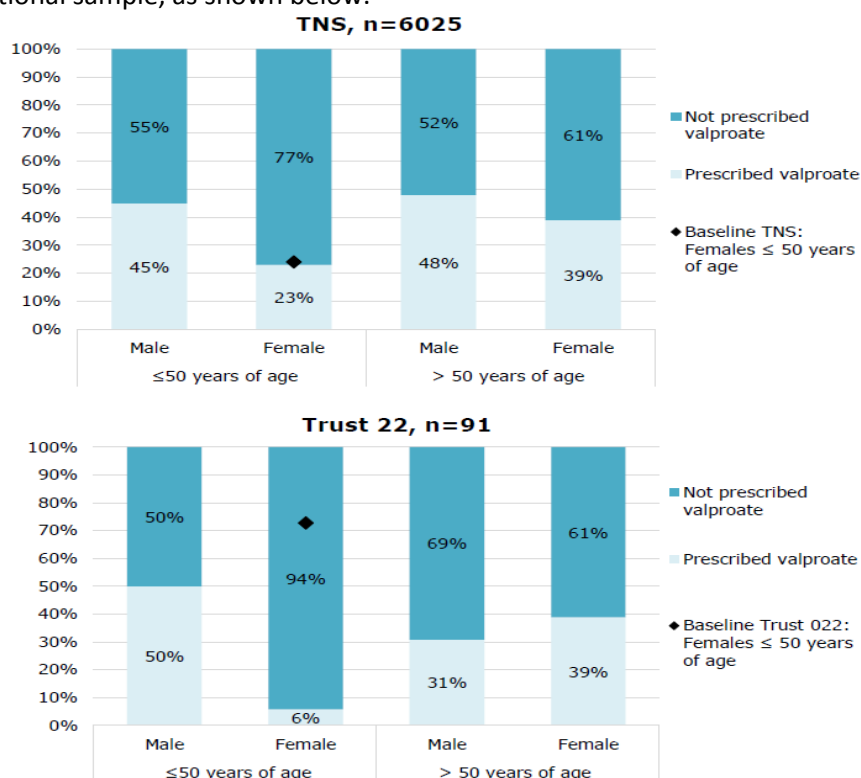


Fig. 29: POMH - valproate prescribing in bipolar illness

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)

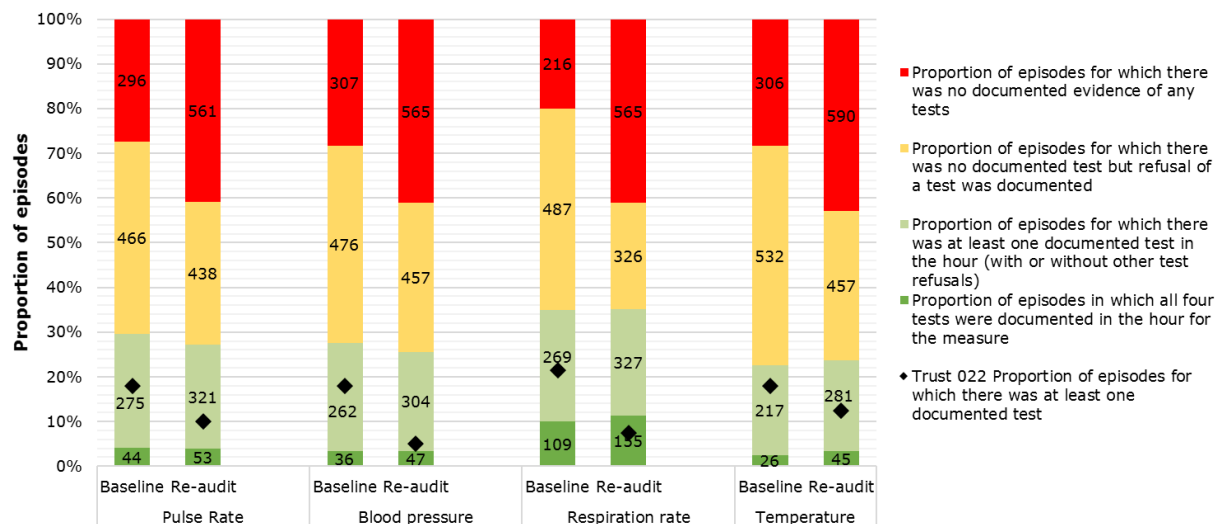


Fig. 30: POMH – Rapid Tranquilisation

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 and the Trust is awaiting the 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.

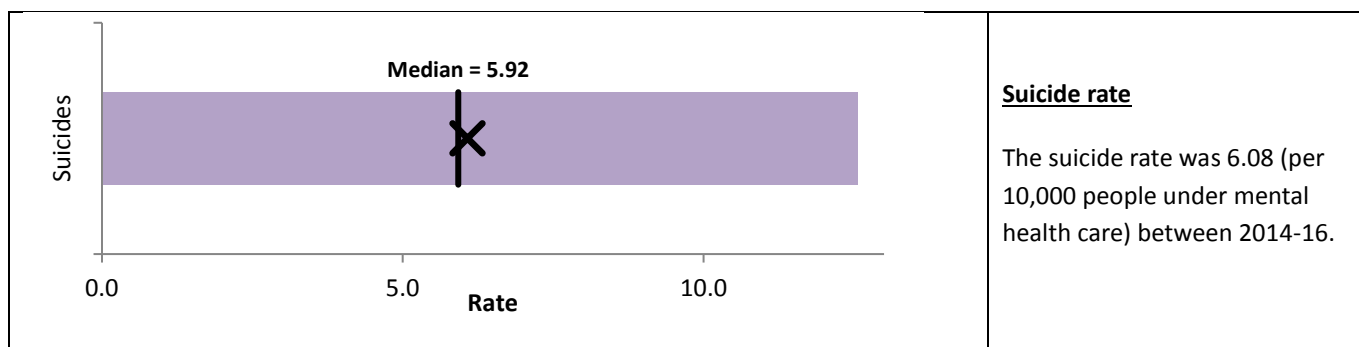


Fig. 31: Suicide Rate (2014-2016)

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

Trust Local Clinical Audit Programme

The reports of ten local clinical audits were reviewed by the provider in 2018/19 and SLaM intends to take the following actions to improve the quality of healthcare provided outlined in the table below.

Audit	Status	Summary	Key outcomes	Key actions
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	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 is monitored and reviewed within the Clinical Policy Working Group according to the agreed checklist.

		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.		
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.	The key action is that the comprehensive action plan derived following the 2017 audit will continue to be implemented and compliance monitored.
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. Where dependent children were identified, not all sections of the child need risk screen were completed (35%). In a small number of cases (10%) current child need risk screens were not sufficient, and where no dependent children were identified the screens were inaccurate in 4% of cases. Where dependent children were identified, not all sections of the child need risk screen were completed (35%).	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.	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.	The audit is informing work to improve staff engagement, and a re-audit in 12 months is recommended.
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.	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>

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.

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 places 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 Executives 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. The warning notice has lapsed and the CQC has confirmed on the basis of improvement that there is no need for further regulatory action.

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.

Further details of the agreed goals for 2017-19 and for the following 12 month period (2019/20) are available electronically at <https://www.england.nhs.uk/nhs-standard-contract/cquin/cquin-17-19/> and <https://www.england.nhs.uk/nhs-standard-contract/cquin/cquin-19-20/>

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 was:

	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.

Patient safety incidents resulting in severe harm or death

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

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

SLaM will improve the route of reporting, by continuing to improve and develop our monthly Serious Incidents Review Group (SIRG) and continuing to drive an open culture focussed on learning and improving safety for patients and staff.

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 the 511 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 Psychological Medicine and Older Adults (PMOA) directorate 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.

A total of three cases in this reporting period were judged to be more than likely than not to have been due to problems in the care provided by the patient. This is 0.59% of all reported deaths.

Q1 2018/19	Q2 2018/19	Q3 2018/19	Q4 2018/19
0 (0%)	0 (0%)	2 (11.11%)	1 (5.88%)

These figures were estimated using an adapted version of the grading system for case reviewers from the 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. The deaths considered in this section are those assessed using the NCEPOD Classification as Several aspects of clinical and/or organisational care that were well below satisfactory requires reporting as Serious Incident or SI.

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 Speech and Language Therapy (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 2018/2019

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.

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.

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 Report 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. SLaM intends to take the following actions to improve this indicator score, and so the quality of its services, by ongoing monitoring through the I-Care programme as part of the trust's quality improvement programme.

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 Report 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.

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.

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

Readmission within 30 days	SLaM
Standard measure is 30 days	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	76%	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 <i>(This is a new requirement for 2017/2018 and reporting begins in Q4/18 which is broken monthly in the data presented.)</i>	Apr-18 – Feb-19 13,439 OBDs	Not specified	✓
8. Ensure that cardio-metabolic assessment and treatment for people with psychosis is delivered routinely in the following service areas: a) inpatient wards b) early intervention in psychosis services c) community mental health services (people on care programme approach)	96% inpatient and 75% community	90% inpatient and 75% community	✓

Fig. 36: Core indicators

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

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

SLaM intends to take the following actions to improve this indicator score, and so the quality of its services: these indicators will continue to be monitored via monthly performance and quality meetings.

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

SLaM intends to take the following actions to improve this indicator score, and so the quality of its services: 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.

Part 3: Other information

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:

Quality priorities 2018 - 2019

Reducing violence	Restraint	Reduce prone restraint to zero within 3 years
		Reduce restraint by 50% over the next 3 years
	Violence & Aggression	Reduce by 50% violence and aggression in inpatient areas over the next 3 years
Right care, right time	Reduce rapid tranquilisation	Reduce the use of rapid tranquilisation by 25% over the next 3 years
	Crisis readmissions	Reduce crisis readmissions by 10%
	Waiting times	Reduce the amount of waiting time from referral to first assessment across all community settings and all care pathways
Service user and carers involvement	Carer engagement	Increase the number of identified carers, friends, family for a person in receipt of care
	Care plans	Increase number of care plans devised collaboratively with service users over the next 3 years
	Recommendation to friends and family by patient	Increase to 90% the number of patients who would recommend the service to friends and family if they needed similar care or treatment
Staff experience	Recommendation as a place to work	Over the next 3 years, increase to 75% the number of positive responses from staff who would recommend the organisation as a place to work
	Staff turnover	Reduce turnover of staff by 10% in a rolling year over next 3 years
	Recommendation to friends and family by staff	Increase to 75% the number of positive responses from staff reporting they would be happy with the standard of care provided by the organisation to family/friends

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 wording of three

	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

indicators (two staffing and one carer) have been clarified. The metric indicators to measure performance in the key 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 overall indicators of change, however, there have been local areas of improvement, for example, an area of particularly good performance is the reduction in use of prone restraint in the Lambeth directorate. We are proud of this change driven by our clinical staff.

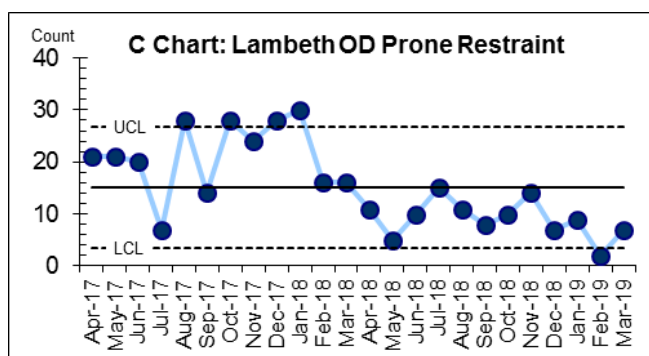


Fig. 8: Lambeth OD Prone Restraint

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 seven-week period in the male PICU where no rapid tranquillisations were used at all.

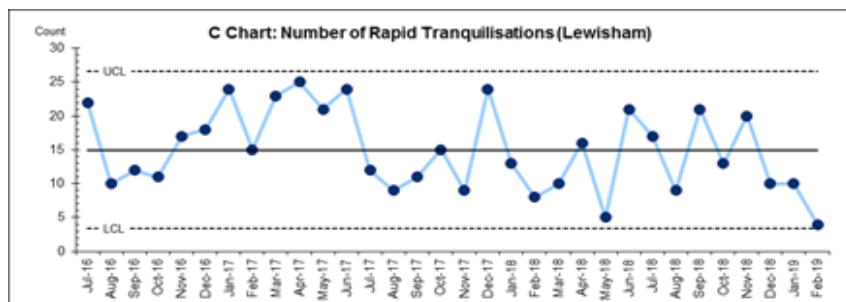
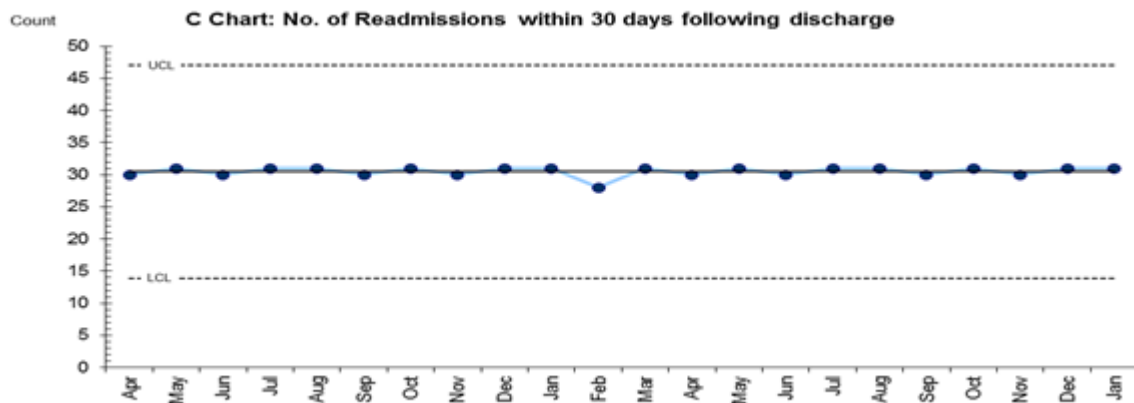


Fig. 10: Lewisham OD Rapid Tranquillisation

	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

Right care, Right time

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

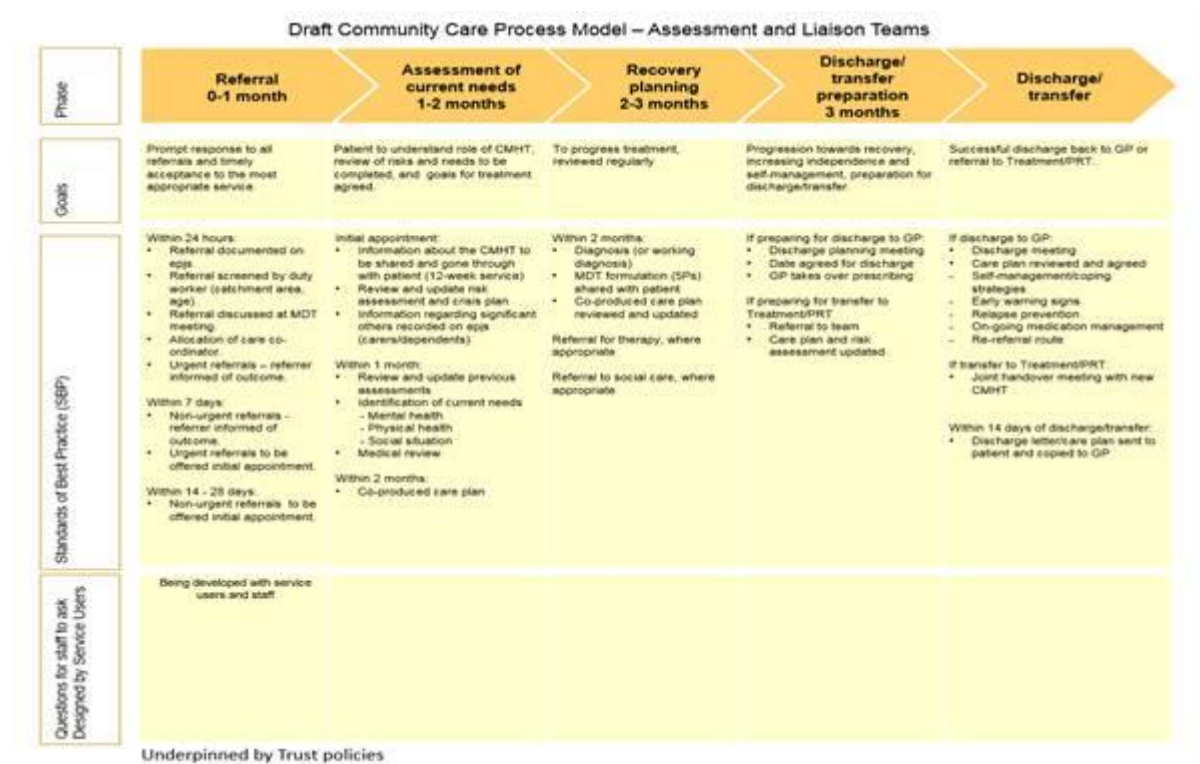
Inpatient Care Process Model (CPM) and expectations of community in the adult acute inpatient care pathway

Inpatient CPM

The inpatient Care Process Model (CPM) has taken ten months to develop and is being tested in Lewisham, prior to being scaled 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 very positive 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 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

Service user and carer involvement

	Trust wide		CAMHS	Croydon & BDP	Lambeth	Lewisham	Southwark & Addictions	PMOA
	17/18	19/20						
Service User and carer involvement								
Increase the proportion of service users under the care of SLAM services who have at least one carer, partner, relative or friend identified, with their contact details recorded on the Core Info section of EPJ.	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		85.36%	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, and 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 Performance and Quality 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 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. The percentage of co-produced care plans has seen a very positive change. We will build on this further to ensure our patients' needs are accurately documented and understood.

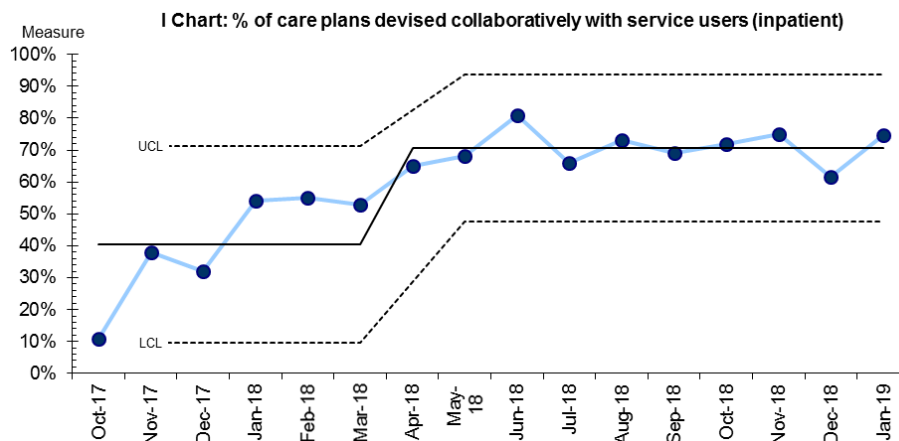
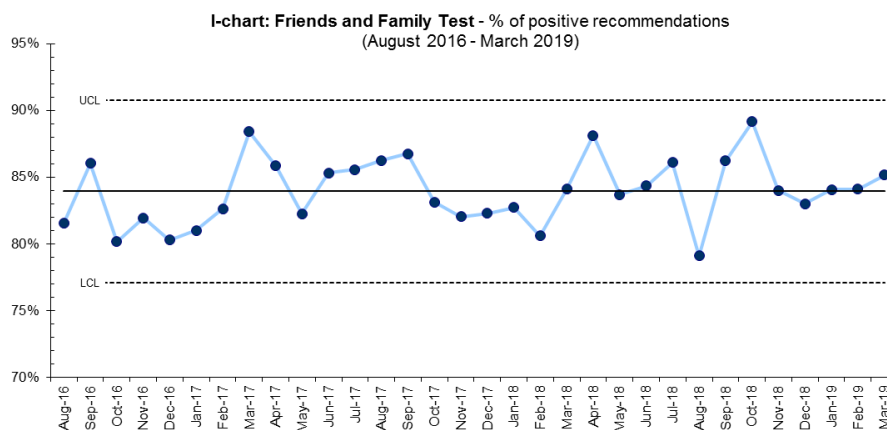


Fig. 11: Percentage of care plans co-produced with service users (Trust wide – inpatient)

Friends and Family Test (FFT)

The trust collects approximately 12,000 Friends and Family Test (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 issue 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 several 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.



	Trust wide		CAMHS	Croydon & BDP	Lambeth	Lewisham	Southwark & Addictions	PMOA
	17/18	18/19						
Staff experience								
Achieving buy-in across the organisation for the need for a large-scale programme of work to enable staff to experience improved satisfaction and joy at work, as measured by reducing turnover rate by 10% in a rolling year over the next three years using the current baseline of 19%. [Quality Priority]	18.6%	18.9%	26.76%	19.69%	17.8%	13.17%	14.06%	17.99%
Increase to 65% of staff who recommend SLaM as a place to work from its current level at 59% by Spring 2020. [Quality Priority]	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

Safer staffing and staff experience

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.

National patient survey of people who use community mental health services 2018

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 2017	Score 2018
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?	6.2/10	6.7/10
Changes in who people see	What impact has this had on the care you receive?	7.6/10	8.2/10

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?	9.4/10
Changes in who people see	What impact has this had on the care you receive?	8.2/10
Organising care	Have you been told who is in charge of organising your care and services?	7.8/10
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?	7.8/10
Treatments	Were these NHS therapies explained to you in a way you could understand?	7.6/10

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?	5.3/10
	In the last 12 months, has someone from NHS mental health services supported you in joining a group or taking part in an activity?	4.7/10
	In the last 12 months, did NHS mental health services give you any help or advice with finding support for financial advice or benefits?	4.1/10
	In the last 12 months, did NHS mental health services give you any help or advice with finding support for finding or keeping work?	3.7/10
	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?	3.6/10

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 several 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.

South London and Maudsley NHS Foundation Trust

Organisation details

Completed questionnaires **1,939**

2018 response rate **43%**

➤ [See response rate trend for the last 5 years](#)

Survey details

Survey mode **Online**

Sample type **Census**

2018 NHS Staff Survey



This organisation is benchmarked against:

Mental Health /
Learning Disability Trusts



2018 benchmarking group details

Organisations in group: **24**

Average response rate: **54%**

No. of completed questionnaires:
36,844

Fig. 15: 2018 NHS Staff survey details

Overall Staff engagement

The graph below highlights Trust performance with staff engagement overall. SLAM performed alongside the average score of 7.0 and the same as 2017.

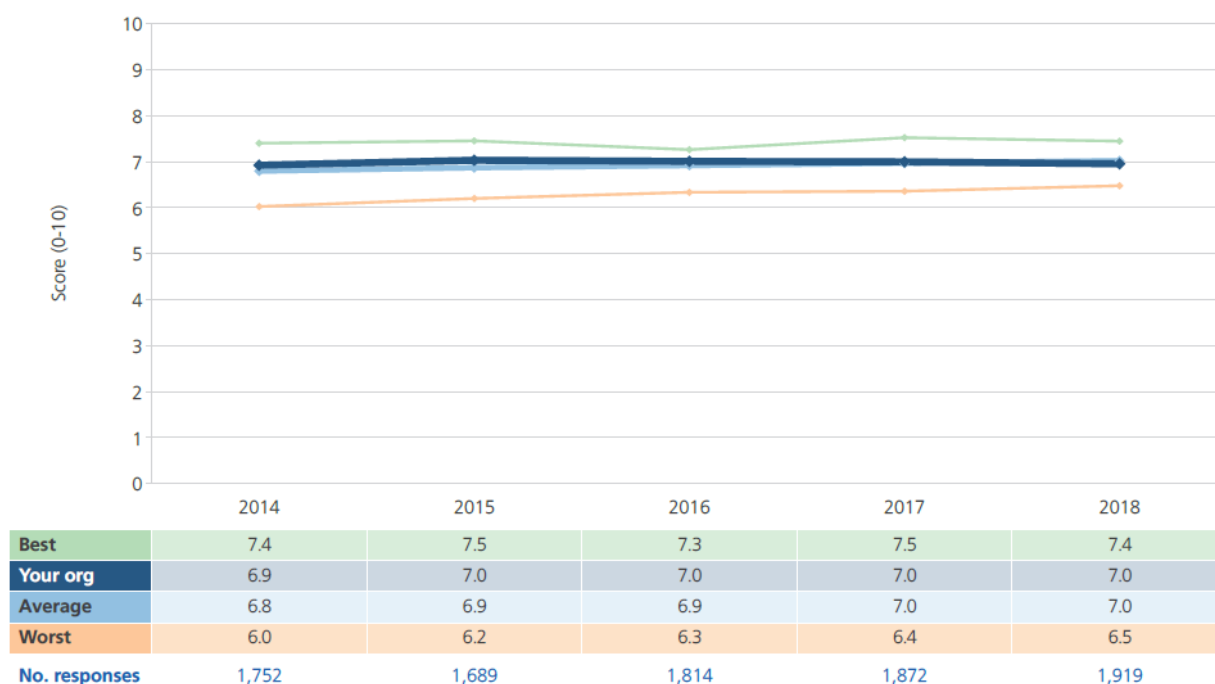


Fig. 16: 2018 NHS Staff survey results – staff engagement

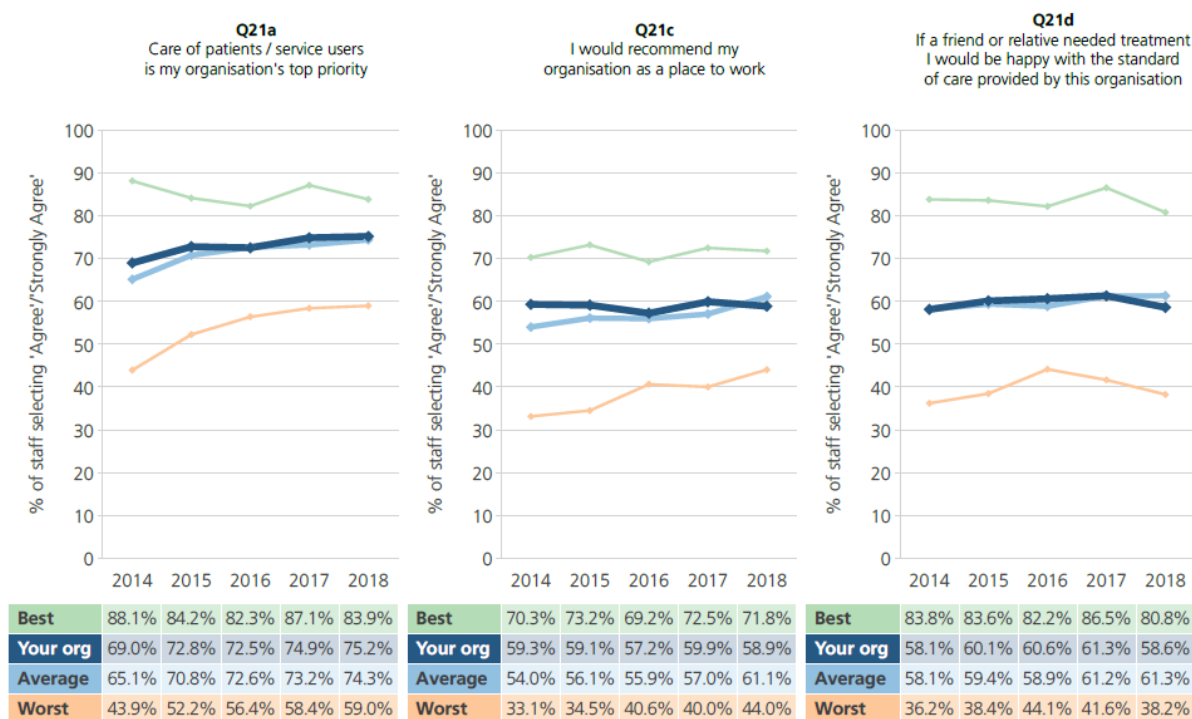


Fig. 17: 2018 NHS Staff survey results – detailed staff engagement theme

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. We are confident that local leadership will make a difference to our staff.

Workforce Race Equality Standard (WRES)

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%
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BME	Trust Score 2017: 26%	Trust Score 2018: 31.6%
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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 to implement 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. We are beginning to see more BME staff represented at Band 7 and above – it is too soon to report a sustained change.

Freedom to Speak Up Guardian (FTSU)

2018/19 has been a busy year for Freedom to Speak Up (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 three new Advocates came forward to join the FTSU Network and cases jumped from nine in Q2 to 19 in Q3.

The CQC in August 2018 scrutinised the FTSU function as part of the Well Led Inspection. They identified three “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 three 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 (FTSUG) 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.

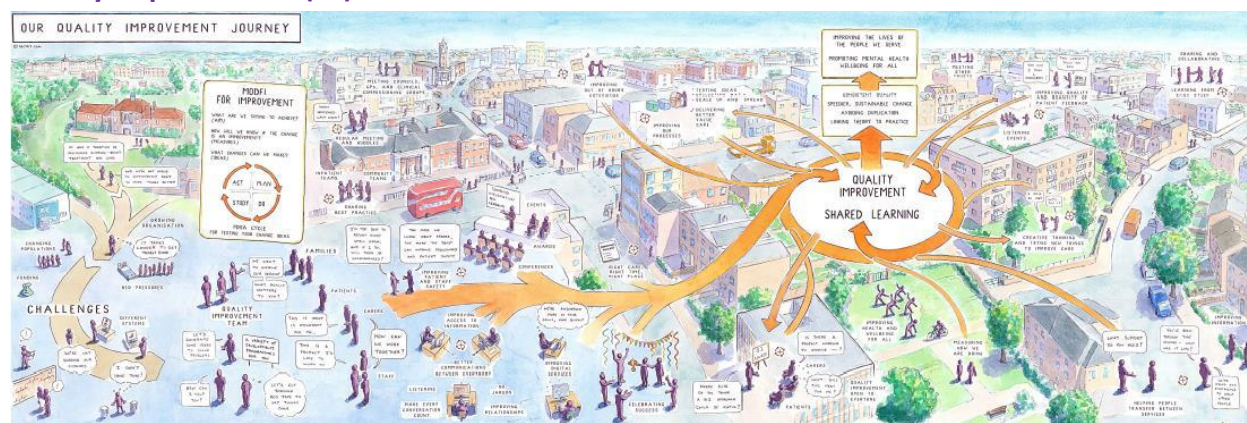
Our priorities for improvement for 2019/2020

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 Quality Improvement (QI) programme and relevant work streams to embed and sustain real improvement. Wording for three indicators has been clarified for 2019/20. Achievement relating to these priorities will be reported in next year's Quality Report.



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 streams are outlined below:

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

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 significant delays in some areas, and teams were not always working at their best across boundaries with teams in other directorates 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 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 directorate, 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 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. Although we have not yet reached the target of a reduction by 50% there are a number of teams that have demonstrated positive and sustained change.

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 SBPs 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 policies 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.

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 Report 2018/19

The Clinical Commissioning Groups contracting with the South London and Maudsley NHS Foundation Trust have welcomed the opportunity to review your Quality Account for 2018–2019. We are able to confirm that it complies with the requirements as set out by NHS England. The Quality Account provides an open and transparent declaration of the status of the quality of the services the Trust provides which is well written and generally easy to navigate. It appears to be at a fairly final draft stage at the point of review.

We have been grateful to the Trust for the way that colleagues have worked openly with us – supporting our assurance processes – taking our concerns seriously and responding to questions helpfully and in a timely way. We are grateful and supportive of the move taken by the Trust during 2018/19 to listen to our concerns and suggestions for improvement in its internal serious incident processes in order to provide us with greater levels of information.

We also note the Trust's engagement and commitment to working in partnership and their open and honest approach to quality. There is widespread appreciation across the four commissioners of SLaM's senior commitment and regular attendance at CQRGs, enabling transparent productive discussions.

Commissioners recognise that the Trust is committed to providing the very best quality care to patients.

We support the Trust's quality priorities for 2019/20 and beyond, noting that that there are fewer priorities than in some previous years and that delivery of these priorities is planned over three years (2018-19 being the second of three years). This makes the achievement of the ambitious targets the Trust has set itself more likely, as a consequence of the clearer prioritisation and the ability to plan over longer timeframes this approach will afford.

We are disappointed that progress against the quality priorities has been slow but are looking forward to an increase in the pace of change. There is recognition amongst commissioners that the Trust has set challenging targets, and look forward to more tangible improvements in 2019/20. The enhanced Quality and Performance report now includes the quality priorities, giving them more profile and the ability to be tracked. This is welcomed by all four commissioners.

We wish to publicly acknowledge the significant amount of work undertaken and sheer focus and application across all grades of staff in response to the CQC inspection. This was demonstrated most clearly by the quick response to the issues raised by CQC in the 2018 core services inspection and the lifting of the improvement notice just into 2019/20. We see this as evidence that SLaM staff are able to make rapid and effective improvement when fully supported to do so.

We are pleased to see feedback about the work of the Freedom to Speak up Guardian and a clear plan for how the Trust intends to learn from this.

The CCGs are looking forward to continuing to work collaboratively with the Trust over the coming year in new partnerships and alliances as we implement wider system changes in support of quality improvement for the benefit of service users in Croydon, Lambeth, Lewisham and Southwark.

Council of Governors' reply to South London and Maudsley NHS Foundation Trust (SLaM) Quality Report 2018/19

The SLaM Governors are drawn from a membership which covers the very wide area of south London served by the Trust. We have aimed over the past year to play a robust and meaningful part in the governance of the Trust, and the Governors value this opportunity to comment on the current year's Quality Accounts. The Governors' Quality Working Group meets four times a year and sends an observer to meetings of both the Quality Committee and the Trust-wide Mental Health Law Committee, who reports the proceedings back to the group.

We have followed closely the effect of the CQC warning notice following the 2018 inspection, and have been aware of the very real efforts made by the Board, the NEDs and the staff as a whole to bring about a more qualitatively even level of service across all pathways of care. We congratulate them on their success, whilst acknowledging the further improvement that can still be made.

We have followed the development of the QI programme at Board meetings and have seen some impressive ideas and outcomes, particularly on the management areas of the Trust's work. Whilst we recognise that this ultimately, of course, has a positive effect on patient experience, and are aware that the key QI initiatives are co-produced with service users, we are looking forward, in future, to hearing examples of service user initiation in QI initiatives.

Stakeholders were surveyed on their general awareness and understanding of the Trust's Quality Priorities and it made interesting reading, showing that not all staff are as aware as they might be of them and how they might/should affect their work. However, this confirms, we feel, the good sense in the decision made to keep the same priorities for three years in order to give them a chance to embed as fully as possible throughout this very large organisation.

Review of the Quality Performance for 2018/19

Patient safety

We accept that the apparent increase in reported incidents of violence and aggression is a recognised effect of increased observation and recording of these events, and are pleased to note that, while no statistically important changes have been signalled in the Trust-wide data graphs, there are significant examples of reduction in prone restraint in Lambeth, and there has been decreased use of Rapid Tranquillisation in Lewisham. We will be eager to see if the data continues to show reduction as this important Quality Priority continues into another year.

Patient experience

We are pleased to see the increase in the number of care plans being co-produced, and the involvement of carers in this process, and hope that this performance will continue to increase in the year ahead.

We are pleased to see that the Trust scores highly in many areas in the *2018 National Community Mental Health Survey*. We note, with particular approval, the "significant shift upwards" in scores in answers to questions about support and wellbeing in relation to carer involvement.

We hope that the disappointing results of the bottom five questions are being noted, and while we understand that there is excellent work being done in some areas in the Trust, we hope that this good practice will extend throughout all the boroughs, so that all service users will eventually get the advice and help that they need, particularly on practicalities such as advice on benefits and job advice.

Safer staffing and staff experience

The wellbeing of staff is crucial for the success of the Trust's work, and is a major concern of the Governors. As the clinical operational structure of SLaM has changed to borough-based directorate, and more focus is placed on community services, we recognise that recruitment and retention of good staff is of prime importance if this change is to have the success that everyone is looking for. Equality and diversity issues have to be fully and successfully addressed. We know that the Board is fully aware of this issue, and that they are committed to finding ways of improving staff experience so that they feel valued, supported and engaged. Many new initiatives have been introduced, but sustained and sympathetic action is needed to ensure their success.

The Freedom to Speak Up Guardian plays a vital role in this work, and we are pleased to see this function making some significant progress.

Priorities for improvement 2019/2020

Staff at all levels of the Trust approached the CQC inspection in July 2018 with their usual energy and are to be congratulated on the overall 'good' rating. The warning notice given for the Acute and PICU pathway for, in the main, inconsistency in quality of care was tackled with similar energy and determination. A new method of reporting and monitoring activity at team level – involving reporting concerns and issues from 'floor' up to the Board – was implemented, huddles happened, changes were wrought and, as a result, the warning notice expired in April 2019. The Governors are fully aware of how much focused effort and hard work went into this undertaking, and know how deserved was the result. We have every hope that the changes will become firmly embedded – and improvements made permanent.

Participation in national quality improvement programmes - Audit

The Governors are interested to see that SLaM has taken part in national audit programmes, thus ensuring that our services are constantly being improved and kept up to the highest national standards.

The Trust has undergone an operational structure change from Clinical Academic Groups to borough-based directorates; we hope that community services – also the focus of a redesign process - will be subject to the same rigorous audits. We are encouraged, therefore, to see that the *National indicators for 2018/2019* and the *National indicators for 2019/2020* require SLaM to report performance against indicators in three areas of community care:

- 1) Care Programme Approach 7-day follow up;
- 2) Home Treatment Team Gatekeeping; and
- 3) Re-admission to hospital within 28 days of discharge.

As these are all significant indicators of the quality of community care (and in (1) contributing to reducing the suicide rate) we are hopeful that good oversight will be kept on these future developments throughout the Trust.

Information Governance

The Trust is to be congratulated on its work to improve its digital competence. In signing up to a unified data-sharing framework across South East London, it has further supported the expansion of the shared care record in this part of London – the Virtual Care Record.

We are aware that SLaM, like NHS organisations throughout the country, has challenges with the consistency and reliability of its digital systems. However, we are also cognisant of the work being done to improve data provision for all its staff, and therefore to contribute to the ultimate improvement in care for its service users. Governors welcome improvements to data quality, and anticipate effective and regular training to make the most of digital tools available to staff.

We might mention here the work being done to develop the Trust's informatics strategy, and to establish the Quality Centre which will provide the basis of Trust-wide data which will prove central to the provision of excellent care for all its service users and staff.

Local Healthwatch organisations' reply to South London and Maudsley NHS Foundation Trust (SLaM) Quality Report 2018/19

No response received

Annex 2

Statement of Directors' Responsibilities in Respect of the Quality Report

The directors are required under the Health Act 2009 and the National Health Service (Quality Accounts) Regulations 2010 to prepare Quality Accounts for each financial year. NHS Improvement has issued guidance to NHS foundation trust boards on the form and content of annual Quality Reports (which incorporate the above legal requirements) and on the arrangements that foundation trust boards should put in place to support the data quality for the preparation of the Quality Report.

In preparing the Quality Report, directors are required to take steps to satisfy themselves that:

- The content of the Quality Report meets the requirements set out in the NHS Foundation Trust Annual Reporting Manual 2018/19 and supporting guidance;
- The content of the Quality Report is not inconsistent with internal and external sources of information including:
 - Board minutes and papers for the period April 2018 to 21 May 2019, including
 - Papers relating to Quality reported to the Board over the period April 2018 to 21 May 2019;
 - Feedback from commissioners dated May 2019
 - Feedback from Governors dated May 2019
 - Feedback from local Healthwatch organisations May 2019
 - The Trusts complaints reports published under regulation 18 of the Local Authority Social Services and NHS Complaints Regulations 2009, Quarters 1, 2, 3 and 4 2018/2019
 - 2018 national patient survey results dated November 2018
 - 2018 national staff survey results dated November 2018
 - The Head of internal audit's annual audit opinion over the Trust's control environment dated 20 May 2018
 - CQC quality and risk profiles published throughout the year
- The Quality Report presents a balanced picture of the NHS foundation trust's performance over the period covered;
- The performance information reported in the Quality Report is reliable and accurate;
- there are proper internal controls over the collection and reporting of the measures of performance included in the Quality Report, and these controls are subject to review to confirm that they are working effectively in practice;
- the data underpinning the measures of performance reported in the Quality Report is robust and reliable, conforms to specified data quality standards and prescribed definitions, and is subject to appropriate scrutiny and review; and,
- The Quality Report has been prepared in accordance with NHS Improvement's annual reporting guidance (which incorporates the Quality Accounts regulations) as well as the standards to support data quality for the preparation of the Quality Report.

The directors confirm to the best of their knowledge and belief they have complied with the above requirements in preparing the Quality Report.

By order of the Board

Signed

A handwritten signature in black ink, appearing to read 'J Mulroy'.

June Mulroy

Chair

South London and Maudsley NHS Foundation Trust

Date: 23 May 2019

Signed

A handwritten signature in black ink, appearing to read 'M Patrick'.

Dr Matthew Patrick

Chief Executive

South London and Maudsley NHS Foundation Trust

Date: 23 May 2019

Annex 3

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 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.” (<i>About CCGs, NHS Clinical Commissioners</i>). 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)	A 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.
Operations Directorates (OD)	<p>In 2018/19, the services SLaM provides were reorganised into Operations Directorates. These directorates are largely organised by borough. This means that the trust can work in close partnership with local organisations and health and social care agencies across all mental health conditions to provide care closer to home. In some instances, our services are provided for national patients or are specialist for specific groups of our local population. In these instances, the care is best managed on a trust-wide basis so that we can concentrate expertise around smaller numbers of patients. Therefore, the new management model brings together Operations Directorates and previous research-focussed Clinical Academic Groups (CAGs) to ensure we have the expertise to offer patients the very best care and treatment, based upon reliable research evidence.</p> <p>The new Operations Directorates are:</p> <ul style="list-style-type: none"> • Child and Adolescent Mental Health Services • Croydon and Forensics • Lambeth • Lewisham • Psychological Medicine and Older Adults • Southwark and Addictions.
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

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.

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 Speech and Language Therapy (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

Independent Practitioners Limited Assurance Report to the Council of Governors of South London and Maudsley NHS Foundation Trust on the Quality Report

We have been engaged by the Council of Governors of South London and Maudsley NHS Foundation Trust to perform an independent limited assurance engagement in respect of South London and Maudsley NHS Foundation Trust's Quality Report for the year ended 31 March 2019 (the "Quality Report") and certain performance indicators contained therein against the criteria set out in the 'NHS Foundation Trust Annual Reporting Manual 2018/19' and additional supporting guidance in the 'Detailed requirements for quality reports 2018/19' (the 'Criteria').

Scope and subject matter

The indicators for the year ended 31 March 2019 subject to the limited assurance engagement consist of the national priority indicators as mandated by NHS Improvement:

- early intervention in psychosis (EIP): people experiencing a first episode of psychosis treated with a National Institute for Health and Care Excellence (NICE)-approved care package within two weeks of referral
- inappropriate out-of-area placements for adult mental health services

We refer to these national priority indicators collectively as "the indicators".

Respective responsibilities of the directors and Practitioner

The directors are responsible for the content and the preparation of the Quality Report in accordance with the criteria set out in the 'NHS foundation trust annual reporting manual 2018/19' and supporting guidance issued by NHS Improvement.

Our responsibility is to form a conclusion, based on limited assurance procedures, on whether anything has come to our attention that causes us to believe that:

- the Quality Report is not prepared in all material respects in line with the Criteria set out in the 'NHS foundation trust annual reporting manual 2018/19' and supporting guidance;
- the Quality Report is not consistent in all material respects with the sources specified in NHS Improvement's 'Detailed requirements for external assurance for quality reports 2018/19'; and
- the indicators in the Quality Report identified as having been the subject of limited assurance in the Quality Report are not reasonably stated in all material respects in accordance with the 'NHS foundation trust annual reporting manual 2018/19' and supporting guidance and the six dimensions of data quality set out in the "Detailed requirements for external assurance for quality reports 2018/19".

We read the Quality Report and consider whether it addresses the content requirements of the 'NHS foundation trust annual reporting manual 2018/19' and supporting guidance and consider the implications for our report if we become aware of any material omissions.

We read the other information contained in the Quality Report and consider whether it is materially inconsistent with:

- Board minutes for the period 1 April 2018 to May 2019;
- papers relating to quality reported to the Board over the period 1 April 2018 to May 2019;
- feedback from commissioners dated May 2019;
- feedback from governors dated May 2019;
- the Trust's internal complaints reports over the period April 2018 to January 2019
- the 2018 national patient survey;
- the 2018 national staff survey;
- the Head of Internal Audit's annual opinion over the Trust's control environment dated 20/05/2019; and
- the Care Quality Commission's inspection report dated 23rd October 2018;

We consider the implications for our report if we become aware of any apparent misstatements or material inconsistencies with these documents (collectively the "documents"). Our responsibilities do not extend to any other information. The firm applies International Standard on Quality Control 1 (Revised) and accordingly maintains a comprehensive system of quality control including documented policies and procedures regarding compliance with ethical requirements, professional standards and applicable legal and regulatory requirements.

We are in compliance with the applicable independence and competency requirements of the Institute of Chartered Accountants in England and Wales (ICAEW) Code of Ethics. Our team comprised assurance practitioners and relevant subject matter experts.

This report, including the conclusion, has been prepared solely for the Council of Governors of South London and Maudsley NHS Foundation Trust as a body, to assist the Council of Governors in reporting South London and Maudsley NHS Foundation Trust's quality agenda, performance and activities. We permit the disclosure of this report within the Annual Report for the year ended 31 March 2019, to enable the Council of Governors to demonstrate they have discharged their governance responsibilities by commissioning an independent assurance report in connection with the indicators. To the fullest extent permitted by law, we do not accept or assume responsibility to anyone other than the Council of Governors as a body, and South London and Maudsley NHS Foundation Trust for our work or this report, except where terms are expressly agreed and with our prior consent in writing.

Assurance work performed

We conducted this limited assurance engagement in accordance with International Standard on Assurance Engagements 3000 (Revised) 'Assurance Engagements other than Audits or Reviews of Historical Financial Information' issued by the International Auditing

and Assurance Standards Board ('ISAE 3000'). Our limited assurance procedures included:

- evaluating the design and implementation of the key processes and controls for managing and reporting the indicators;
- making enquiries of management;
- limited testing, on a selective basis, of the data used to calculate the indicators tested against supporting documentation;
- comparing the content requirements of the 'NHS foundation trust annual reporting manual 2018/19' and supporting guidance to the categories reported in the Quality Report; and
- reading the documents.

A limited assurance engagement is narrower in scope than a reasonable assurance engagement. The nature, timing and extent of procedures for gathering sufficient appropriate evidence are deliberately limited relative to a reasonable assurance engagement.

Limitations

Non-financial performance information is subject to more inherent limitations than financial information, given the characteristics of the subject matter and the methods used for determining such information.

The absence of a significant body of established practice on which to draw allows for the selection of different, but acceptable, measurement techniques that can result in materially different measurements and can affect comparability. The precision of different measurement techniques may also vary. Furthermore, the nature and methods used to determine such information, as well as the measurement criteria and the precision of these criteria, may change over time. It is important to read the Quality Report in the context of the criteria set out in the 'NHS foundation trust annual reporting manual 2018/19' and supporting guidance.

The scope of our limited assurance work has not included governance over quality or non-mandated indicators, which have been determined locally by South London and Maudsley NHS Foundation Trust.

Our audit work on the financial statements of South London and Maudsley NHS Foundation Trust is carried out in accordance with our statutory obligations and is subject to separate terms and conditions. This engagement will not be treated as having any effect on our separate duties and responsibilities as South London and Maudsley NHS Foundation Trust's external auditors. Our audit reports on the financial statements are made solely to South London and Maudsley NHS Foundation Trust's members, as a body, in accordance with paragraph 24(5) of Schedule 7 of the National Health Service Act 2006.

Our audit work is undertaken so that we might state to South London and Maudsley NHS Foundation Trust's members those matters we are required to state to them in an auditor's report and for no other purpose. Our audits of South London and Maudsley NHS Foundation Trust's financial statements are not planned or conducted to address or reflect matters in which anyone other than such members as a body may be interested for such purpose. In these circumstances, to the fullest extent permitted by law, we do not accept or assume any responsibility to anyone other than South London and Maudsley NHS Foundation Trust and South London and Maudsley NHS Foundation Trust's members as a body, for our audit work, for our audit reports, or for the opinions we have formed in respect of those audits.

Conclusion

Based on the results of our procedures, as described in this report, nothing has come to our attention that causes us to believe that, for the year ended 31 March 2019:

- the Quality Report is not prepared in all material respects in line with the Criteria set out in the 'NHS foundation trust annual reporting manual 2018/19' and supporting guidance;
- the Quality Report is not consistent in all material respects with the sources specified in NHS Improvement's 'Detailed requirements for external assurance for quality reports 2018/19'; and
- the indicators in the Report identified as having been subject to limited assurance have not been reasonably stated in all material respects in accordance with the 'NHS foundation trust annual reporting manual 2018/19' and supporting guidance.

Grant Thornton UK LLP

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29th May 2019