South London and Maudsley NHS
NHS Foundation Trust

**REPORT TO THE Croydon Scrutiny Committee**

**23 April 2018**

| | |
|---|---|
| **Title** | **Draft Quality Accounts version 5** |
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| **Responsible Director** | **Beverley Murphy, Director of Nursing** |

**Purpose of the report**

This report to the Quality Committee sets out:

The Fifth draft of the Quality Accounts 2017/2018 with information available at point of drafting- ***TO NOTE STILL AWAITING END OF YEAR DATA for Quality Indicators.***

- To note the NHSI mandated areas outlined in the report.
- To review and discuss proposed priorities for 2018/2019 (page 19) and subsequent quality measurement indicators based on the feedback through various consultation processes of which Service User and Carer feedback is outlined in separate report.
- Following 09 April Quality Committee in structure have been made, which include the following:

1. Agreed four quality priority domains as a result of wide consultation and quality committee agreement- see below


2. The key measurement indicators to be agreed at the Quality matters Committee

**Performance against 17/18 priorities**

We realise that last year we set some targets in line with our Quality Improvement strategy that were ambitious. Whilst we did not achieve the targets that we wanted in the first year, in most cases we are moving in the right direction of travel.

South London and Maudsley NHS
NHS Foundation Trust

# DRAFT Quality Account for 2017/2018

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# Part 1: Statement on quality from the Chief Executive of the NHS Foundation Trust

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

This year the Trust launched it's 'Changing Lives' strategy. Central to this is our ambition to deliver outstanding care and to support the achievement of outstanding outcomes and experience for the people who we work with and serve. This can only be achieved by working in close partnership with service users, carers, communities and with our own workforce. We are also moving to whole population contracts in all our boroughs so that we can deliver better outcomes for all.
A key feature in 'Changing Lives' is a relentless focus on quality of care through our Quality Improvement Programme (QI), now in its second year. This year has been an important year in embedding QI across the organisation. There are now well over a hundred Quality Improvement projects being taken forward across the length and breadth of the Trust, each helping us to drive improvements and share learning. More than 400 staff have now been trained in the approach, including around 70 of our leaders. These Quality Improvement projects directly empower our staff to suggest and test improvements to the way that they work and the services they provide.

We know that we will only get the development and delivery of our services right if we work in close partnership and co-production with our service users, their families and carers in the development and delivery of services. The importance we attach to this is reflected in our setting co-production and involvement as the very first of the aims of our Changing Lives strategy.

As part of our commitment to improving standards of quality and safety, members of the senior management team, often accompanied by Non-Executive Directors, are carrying out leadership and safety visits to every single team in SLaM by the end of 2018. Our aim is for these 'leadership walkarounds' to increase staff engagement and develop a culture of open communication, making it easier for staff to raise concerns and for us to hear first-hand about the safety concerns of front-line staff. We also want to be able to identify and celebrate areas of good practice and opportunities for embedding them more widely across the Trust. I have found it really helpful to hear from staff in person about how they felt quality and safety could be improved and to hear about some of the tremendous work already going on. What comes through very clearly is a hugely impressive commitment to quality. The themes and actions from each visit are captured and monitored so that quick progress can be made in relation to the issues that are identified.

We realise that last year we set some targets in line with our Quality Improvement strategy that were ambitious. Whilst we did not achieve the targets that we wanted in the first year, I was pleased to see that in most cases we were moving in the right direction and making progress. Our aim is for this to continue over the longer timeframe of improvement that we have set out in this report.

Finally, whilst we are still currently rated overall 'Good' with the Care Quality Commission (CQC), there are some areas we are aware still require continued improvement. This was made apparent during our Community Adult Pathway CQC inspection in July 2017. The improvement initiatives are part of the wider Quality Improvement programme.

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

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

Dr Matthew Patrick
**Chief Executive Officer**

## A summary of successes and developments in 2017/2018

**Patient Experience**

85% of patients would recommend SLAM services to friends and family.

96% of patients said they found staff to be kind and caring.

**Quality Improvement**

Quality Improvement has rolled out across the organisation. Four Steps to Safety has had a big impact on the incidence of violence and use of restraints on some of our wards. Some teams are seeing an 80% reduction in violent incidents.

**Digital and Mobile Health Technology**

NHS England declared SLaM as London's first mental health 'Global Digital Exemplar'. Funding has helped ensure care is more personalised and responsive to patient needs.

**Awards/Accreditations**

The new SLaM STAR programme has been launched to give recognition to the hard work and dedication of staff.

Two psychiatrists won prestigious Royal College of Psychiatrists Awards

The Eating Disorders Service (FREED) won a Positive Practice in Mental Health Award.

HSJ Awards – Maudsley Simulation (the UK's first centre for mental health simulation) was highly commended for 'improving outcomes through learning and development' having now trained more than 5,000 healthcare professionals.

The Psychology in Hostels project, which places psychologists in homeless hostels, was also highly commended for 'most effective adoption and diffusion of existing best practice'.

**External Organisations**

SLaM has worked closely to develop its relationships with Oxleas and South West London and St Georges with the formation of the South London Partnership. SLP's key achievement to date is the new model of care across forensic mental health services – taken on the total budget for forensic services for South London.

**Other Successes**

More than 50% of frontline staff have now been vaccinated against the flu, which is a significant increase from previous years, making SLaM the most improved NHS Trust.

## …..and what we can do better.

- **We need to continue to embed a culture of continuous improvement across the organisation, ensure staff have the training and support they need, and patients and service users receive safe, quality care.**
- **Improve the experience of BME staff – 40% of the workforce. Trust objectives will be set out to ensure staff are represented at senior pay grades that reflect the proportion of BME staff in the workforce.**
- **Continue to embed new ways of working to reduce violence on Inpatient Wards.**
- **Improve on CQC Community pathway actions, including workforce (staff morale, recruitment, good supervision, caring staff, etc.); lone working; access to advocacy; medicine management; clear governance structures; interagency working (police and social services, etc.); innovative treatments; and flexible working with patients.**

All these have been translated into quality priorities for 2018/19.

### Trust Activity

Awaiting annual report info

# Part 2: Review of quality performance 2017/2018

## Review of progress made against last year's priorities

Our 2017/2018 quality priorities were selected after consultations with stakeholders and staff from our services. The following summarises progress made against each priority over the year.

| **Patient Safety** | **Services Applicable to** | **2016/17** | **2017/18** | **Data source** |
|---|---|---|---|---|
| **Reducing Restrictive Interventions** Reduction of 50% in prone restraint | Inpatient services | 874 | 844 (↓3.4%) | DATIX |
| **Violence & Aggression Reduction** Violence and aggression reduction of 50% | Inpatient services | 1763 | 1664 (↓5.6%) | DATIX |
| **Staffing** >50% wards reduction of average inpatient ward breaches per month | Inpatient services | 20 wards | 12 wards | Safer staffing monthly returns |
| **Clinical Effectiveness** | **Services Applicable to** | **2016/17** | **2017/18** | **Data source** |
| **Digital Health** Further develop electronic systems to improve delivery of care (eObs) across all Trust service areas (>50% of all Adult inpatient wards) | Inpatient services | 2 wards started piloting digital health in their services | 2 wards are using digital health in their services | |
| **Physical Health Awareness** Ensure clinical and non-clinical staff have received level 1 physical health awareness training across all Trust service areas (target 65%) | All service areas | N/A | 77.74% | Education & Training |
| **Physical Health Screening & Intervention** Inpatients and early intervention patients will have 90% or greater rates for each metabolic screening parameter and, where indicated, interventions | All service areas | Inpatient: Screening: 77% Intervention: 60%<br><br>Community: Screening: 41% Intervention: 51%<br><br>Early Intervention: Screening: 52% | Inpatient: Screening: 84% Intervention: 65%<br><br>Community: Screening: 41% Intervention: 46%<br><br>Early Intervention: Screening: 52% | CRIS |

| | | | | |
|---|---|---|---|---|
| | | Intervention: 61% | Intervention: 38% | |
| **Patient Experience** | **Services Applicable to** | **2016/17** | **2017/18** | **Data source** |
| **Family & Carer Engagement** Ensure Family and Carer Engagement. 75% of identified carers in all Trust service areas will have been offered a Carers' Engagement and Support Plan | All service areas | N/A | 9.2% | Carer's Engagement & Support Dashboard |
| **Care Closer to Home: Inpatient Admission** Reduction in overall admissions because patients are better managed in their illnesses at home as is appropriate: 10% reduction in admissions in Trust Inpatient Adult Services | Inpatient services | N/A | 8.0% reduction (To be updated) | Performance and Contract |
| **Care Closer to Home: Length of Stay** Reduction in overall admissions because patients are better managed in their illnesses at home as is appropriate: 30% reduction in admissions in Length of Stay (LoS) in Trust Inpatient Adult Services | Inpatient services | N/A | 2.2% Reduction (To be updated) | Performance and Contract |
| **Staff Experience** | **Services Applicable to** | **2015/16** | **2017/18** | **Data source** |
| **Staff Health and Wellbeing** Increase of 5% of staff reporting the organisation definitely takes positive action on health and wellbeing (CQUIN) | All service areas | 25% | 26% (↑1%) | Staff Survey |
| **Management of work-related stress** Decrease of 5% of staff saying that they have felt unwell in the last 12 months as a result of work-related stress (CQUIN) | All service areas | 43% | 41% (↓2%) | Staff Survey |
| **Staff recommendation of the organisation as a place to work** Achieve >70% on average across the year of staff reporting that they would recommend the organisation as a place to work | All service areas | 2016/2017 63% | 63% (Q1-3 results. To be updated with Q4) | Staff Survey |
| **Key:** | Target achieved | Positive Progression towards target | Regression from target | |

## National patient survey of people who use community mental health services: SLaM report 2017

SLaM scored 'about the same' as most other trusts that took part in the 2017 National Community Mental Health Survey. It is pleasing to note that two individual questions (getting help in a crisis and seeing services often enough) scored 'better' than most other trusts. The trust's highest scoring question was respondents knowing how to contact the person in charge of their care if they had concerns (9.6), and knowing who to contact out of hours if experiencing a crisis scored its highest result since the survey was redeveloped in 2014 (7.2). The three questions where the trust had the greatest increase in performance in 2017 compared to 2016 are being given information about peer support (+0.9), being given help or advice with finding support for financial advice or benefits (+0.9) and staff checking how the service user is getting on with their medication (+0.8).

| Section | Highest performing questions | Number |
|---|---|---|
| Organising care | Do you know how to contact this person if you have a concern about your care? | 9.6 |
| Organising care | How well does this person organise the care and services you need? | 8.3 |
| Health and social care workers | Did the person or people you saw listen carefully to you? | 8.2 |

| Section | Greatest increase in performance from 2016 | Number |
|---|---|---|
| Support and wellbeing | 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? | +0.9 |
| Support and wellbeing | In the last 12 months, did NHS mental health services give you any help or advice with finding support for financial advice or benefits? | +0.8 |
| Treatments | In the last 12 months, has an NHS mental health worker checked with you about how you are getting on with your medicines? | +0.8 |

***Table Five: national Community Mental Health Survey (2017) top performing questions***

Unlike the National Community Mental Health Survey, the National Mental Health Inpatient Survey is entirely voluntary. A total of 18 mental health trusts opted to take part in the 2017 survey. The trust scored 'about the same' or 'worse' as most other trusts, apart from one which scored 'better' (knowing how to make a complaint). The three highest performing questions in 2017 were not sharing a sleeping area with patients of the opposite sex (94%), being contacted by staff since leaving hospital (84.9%) and feeling welcome upon arrival on a ward (78.9%).

To further improve experience of services, the trust continues to implement the Patient and Public Involvement (PPI) strategy and report to the Involvement Oversight Group, which in turn reports to the Quality Sub-Committee. The PEDIC Governance Committee continues to ensure that the trust's local survey programme provides a consistent approach to collecting feedback outside the national survey programme. As the response rate for the national surveys is relatively low, 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.

## National Staff Survey 2017 – Results

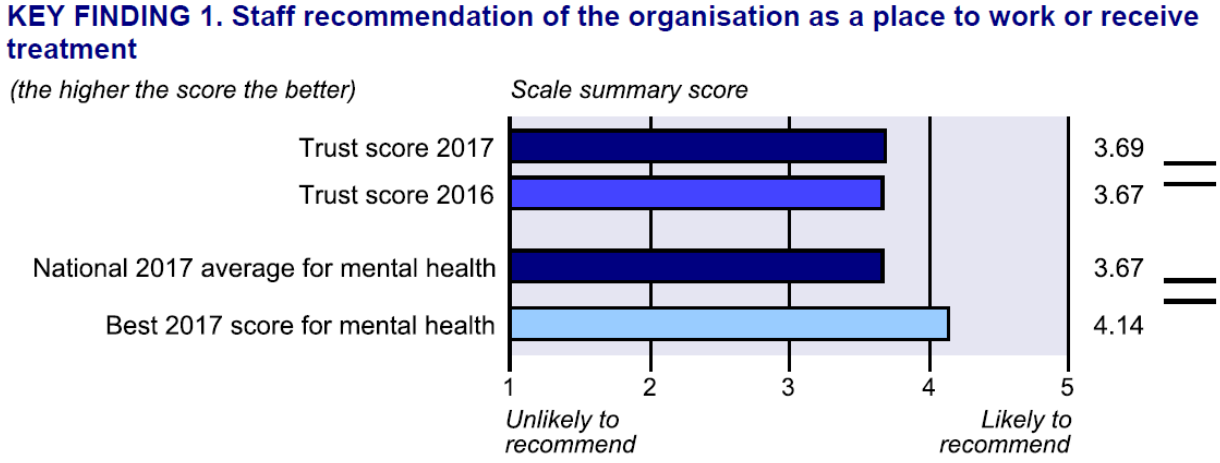
1883 staff at South London and Maudsley NHS Foundation Trust took part in this survey. This is a response rate of 44% which is below average for mental health/ learning disability trusts in England (52%), and compares with a response rate of 40% in this trust in the 2016 survey.

### Number of Staff recommending the Trust

In the 2017 survey, SLaM performed slightly higher to the year before on the question 'would staff recommend the trust as a place to work or receive treatment?' SLaM performed slightly above the national average on this question. The SLAM Trust score for this question was 3.68 compared to the national average score of 3.67 for other mental health trusts.

| | | Your Trust in 2017 | Average (median) for mental health | Your Trust in 2016 |
|---|---|---|---|---|
| Q21a | "Care of patients / service users is my organisation's top priority" | 74% | 73% | 72% |
| Q21b | "My organisation acts on concerns raised by patients / service users" | 73% | 75% | 74% |
| Q21c | "I would recommend my organisation as a place to work" | 60% | 57% | 58% |
| Q21d | "If a friend or relative needed treatment, I would be happy with the standard of care provided by this organisation" | 61% | 61% | 61% |
| KF1. | Staff recommendation of the organisation as a place to work or receive treatment (Q21a, 21c-d) | 3.68 | 3.67 | 3.67 |

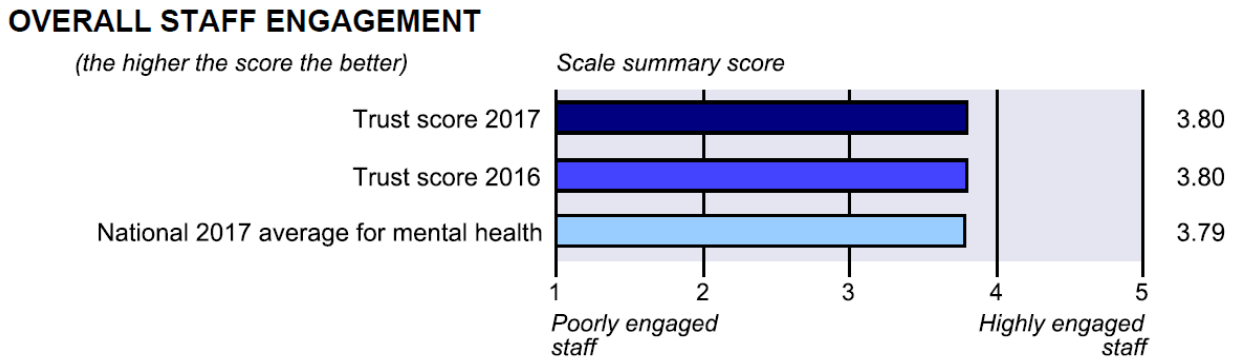
***Table six: National staff survey results***




***Graph one: National staff survey results – key finding 1***

### Overall Staff Engagement

The Trust score for overall staff engagement has remained at **3.80** (3.80 in 2016). This is slightly higher than the national average for all mental health/learning disability Trusts which was 3.79.




***Graph two: National staff survey results – overall staff engagement***

**Key Findings – overall Trust**

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

- Percentage of staff appraised in last 12 months.
  **Trust Score: 94%** **National Average: 89%**

- Effective use of patient/ service user feedback (scale summary score).
  **Trust Score: 3.84** **National Average: 3.72**

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

- Staff recommendation of the organisation as a place to work or receive treatment
  **Trust Score: 3.69** **National Average: 3.67**

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

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

- Percentage of staff working extra hours (the lower the score the better)
  **Trust Score: 77%** **National Average: 72%**

- Percentage of staff satisfied with the opportunities for flexible working patterns
  **Trust Score: 53%** **National Average: 60%**

- Percentage of staff/ colleagues reporting most recent experience of harassment, bullying or abuse
  **Trust Score: 57%** **National Average: 61%**

- Percentage of staff experiencing physical violence from staff in last 12 months (the lower the score the better)
  **Trust Score: 4%** **National Average: 3%**

- Percentage of staff believing that the organisation provides equal opportunities for career progression or promotion
  **Trust Score: 76%** **National Average: 85%**

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

- Fairness and effectiveness of procedures for reporting errors, near misses and incidents
  **Trust Score 2016: 3.73** **Trust Score 2014: 3.65**

- Percentage of staff reporting good communication between senior management and staff
  **Trust Score 2015: 34%** **Trust Score 2014: 30%**

Workforce Race Equality Standard

- Percentage of staff experiencing harassment, bullying or abuse from staff in last 12 months
  **White** **Trust Score 2017: 33%** **Trust Score 2016: 34%**

  **BME** **Trust Score 2017: 34%** **Trust Score 2016: 35%**

## Freedom to Speak up Guardian

This year has seen further activities to embed the Freedom to Speak Up ethos across the Trust. The first Freedom To Speak Up Guardian's Annual Report was made to the Board in March 2018 and a link is provided here to it:

http://www.slam.nhs.uk/media/490535/march_2018_board_papers.pdf.

In summary the report sets out the requirement for the function and how it is organised within the Trust. A detailed Communication Plan has been developed to ensure that the function becomes much more widely known across the Trust as well as promoting the availability of local Advocates who are organised on a Borough basis. FTSU is included in the ambit of the Equalities and Workforce Committee and there have been two reports to that committee about the function. One was to shape the content of the Annual Report and one was to approve the production of a Trust Statement on the Abuse of Power - a draft of this is included in the Annual Report as an Appendix. The Annual Report also sets out the approach that has been taken with people seeking to use its services and summarises the themes and issues emerging. Finally it also contains reference to the work at KHP, London Region and National level.

## SLaM Equality Information and Objectives

The Trust published its annual equality information in January 2018. This includes 2017 Trust-wide equality information that provides information on the demographic profile of the Trust's service users and the experience of service users with different protected characteristics.

We also continue to publish local ethnicity reports for Croydon, Lambeth, Lewisham and Southwark. These provide information on the ethnicity of service users accessing 12 of the Trust's services and the experience of service users of different ethnicities in each borough. This year's report also includes outcome data for Improving Access to Psychological Therapies Services (IAPTs) and an increase in activity to provide effective and responsive services for Black and minority ethnic (BME) service users.

The Trust continues to deliver CAG equality objectives for 2017-20. A high-level summary of these is provided below:

- **Acute Care CAG:** To improve access and experiences for service users with learning disabilities in acute wards.
- **Addictions CAG:** To improve access to substance misuse services in Wandsworth for men who have sex with men.
- **Behavioural and Developmental Psychiatry CAG:** To improve the physical health of Black and Minority Ethnic service users in forensic inpatient services.
- **Child and Adolescent Mental Health CAG:** To improve access and experiences for Asian and Black girls in CAMHS community services.
- **Mental Health of Older Adults and Dementia CAG:** To achieve earlier access to memory services in Lambeth and Southwark for Black service users.
- **Psychological Medicine and Integrated Care CAG:** To improve communication with disabled service users in assessment and liaison teams.

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

Trust-wide Equality objectives relating to service delivery are being developed. Evidence from a range of sources suggests that the priority areas for equality improvement in service delivery should be working to improve access, experience and outcomes for service users and carers who are from BME backgrounds, disabled, lesbian, gay, bisexual or transgender (LGBT).

The Trust's Board has also set clear ambitions in relation to the Trust's BME workforce. These are supported by a detailed action plan that was agreed by the Board in September as part of the paper on the Workforce Race Equality Standards. The Board set the Trust the challenge by spring 2021 to:

- Achieve representation of BME staff at pay bands 8C and above that reflects the proportion of BME staff in our workforce.
- Eliminate the over-representation of BME staff involved in disciplinary proceedings.
- Improve the Career Opportunities offered for BME staff.

# Part 3: Priorities for Improvement and statements of assurance from the Board

## Our priorities for improvement for 2018/2019

Over the last year we have listened to feedback from service users, their families, carers, staff, local Healthwatches, Council of Governors as well as commissioners and regulators. A Trust Quality priority setting event was held on the 21nd February 2018 with stakeholders. This feedback alongside feedback from CQC focused visits in in 2017 as well as Trust information from complaints, serious incidents and audits has helped us to identify our future priorities.

The Trust has invested in developing further the learning and improvement culture and will continue the work underway to ensure outcomes from both CQC Compliance and CQC Mental Health Act (MHA) inspections, incidents and complaints will all be used to improve the care we deliver.

This year has seen the launch of the Trust's five year strategy, 'Changing Lives'.

## What is #Changing Lives?

Changing Lives is the name given to the Trust's five-year strategy 2017-2022

Changing Lives describes the Trust's strategy to improve patient care and the mental wellbeing of people in our wider communities

Changing Lives goes beyond our current focus on the most unwell people in our communities and our specialist services

It aims to contribute to improving the mental health and wellbeing of the whole population that we serve

### Through #ChangingLives the Trust ambition is to…..

Deliver **outstanding care** and change the lives of people living with mental illness.

We will do this through our pioneering **research**, having a relentless focus on quality, working in **partnership** with our patients, staff and stakeholders and making sure our **workforce** is happy and supported.

We will do this while making sure our organisation maintains **financial sustainability.**

**#ChangingLives has eight aims…**

Move to whole-population contracts in all our boroughs, to deliver better population outcomes, starting with the Lambeth Alliance in April 2018

Work in partnership with our service-users, their families and carers in the development and delivery of services

Deliver outstanding care and services including achieving CQC 'Outstanding' by April 2021

Ensure we value, develop, involve and empower our staff

Develop profitable commercial ventures that will enable us to further support and invest in our local services

Work with our partners in Oxleas and South West London and St George's to improve the delivery and reach of our national and specialist services

Improve the translation of research into clinical practice and develop a successful, international fundraising campaign for the early detection of mental ill health, including a new institute for Children and Young People's Mental Health

Ensure we are financially sustainable and governed to the highest possible standards

## What will be different?

**Our focus in the past** → **Our focus now**

| Our focus in the past | Our focus now |
|---|---|
| • Providing 'good' care<br>• A focus on the 'most unwell' in our communities<br>• An 'assumption' of quality care<br>• The Trust has most of the answers and can solve issues independently<br>• Recognising the importance of staff and patient engagement<br>• Research excellence | • Outstanding care<br>• A focus on the whole population<br>• QI at the heart of the Trust's culture and strategy<br>• The Trust works in partnership with others to solve issues<br>• Actively engaging with staff and patients and focus on working in true partnership<br>• Research excellence embedded in organisation, supporting population health and care. |

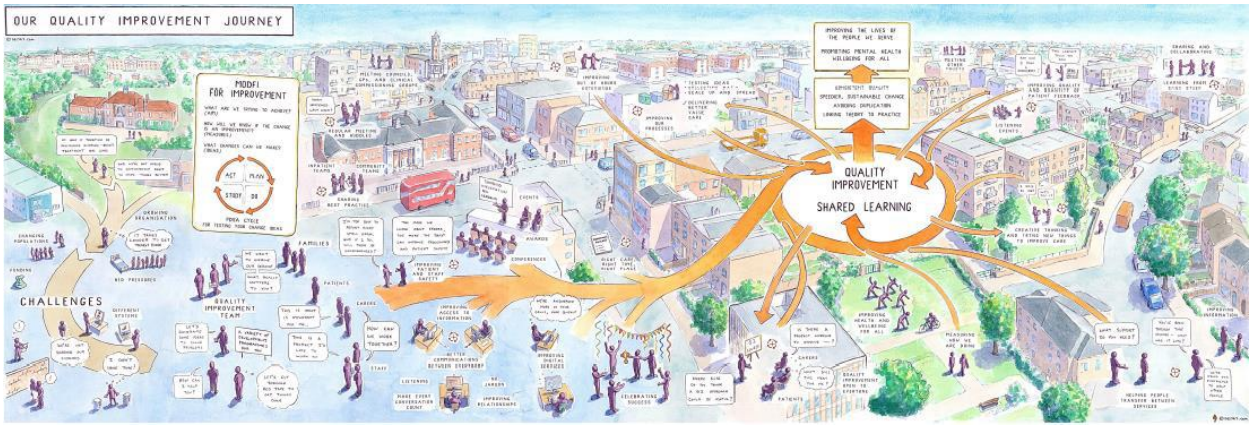
## Staff are a key part of changing lives……

Priscilla, helping to change lives by manning the phones for our 24 hour mental health support line

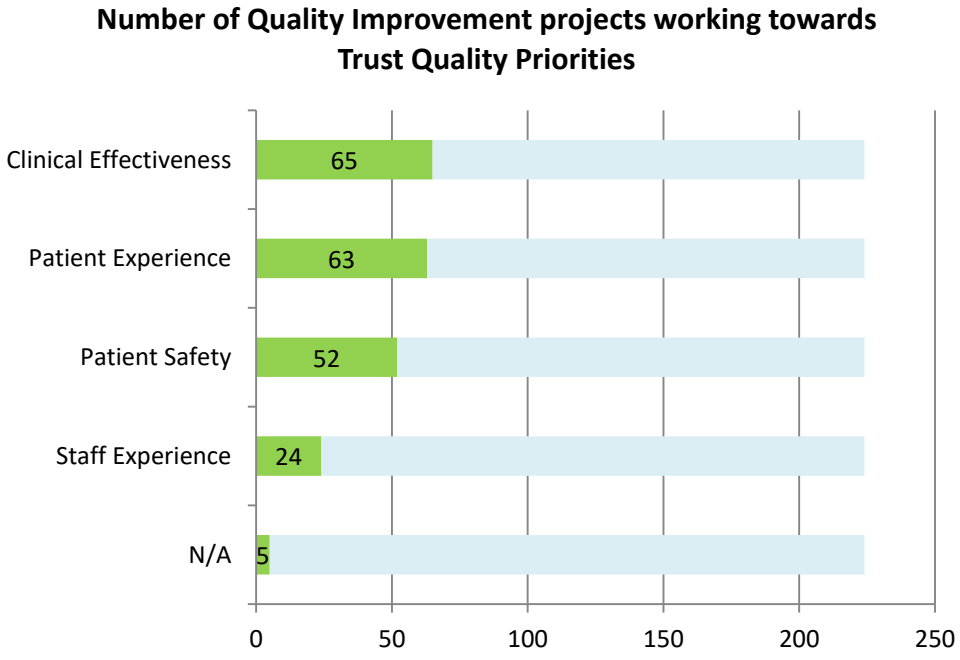

The Crisis Assessment Team are changing lives by getting mental health services to service users as soon as possible

## Quality Improvement

The Quality Improvement programme now in its second year and is now seeing a real culture change in the principles of QI being embedded across the Trust. This is has resulted in approximately 350 trained staff in QI methodology across the trust. Service user and carer engagement in QI initiative started in May 2017 to improve care and outcomes for adults in acute care (I-care). There is now greater QI awareness and Foundation QI Training with staff, services users, carers & partner organisations which has resulted in jointly doing QI projects. The Trust is developing an improved method for co-production to be in place by April 2018




There are a total of 224 quality improvement projects underway in the Trust, with 219 working towards to the Trust Quality Priorities. 53 of the projects cover more than one priority.




***Graph three: QI projects working towards Trust Quality Priorities***

## Quality Priorities 2018/19

The priorities for 2018/2019 have been arranged under four areas outlined below which incorporate the broader domains of patient safety, clinical effectiveness, patient experience and staff experience. This year has fewer priorities, each with a number of measurement indicators as outlined below. Progress on achievement of these priorities will be reported on in next year's Quality Accounts.


The metric indicators TO BE AGREED AND CONFIRMED At the Quality Matters Committee dated 17/04/18 to measure performance in the key priorities are outlined below:

| | | | | | |
|---|---|---|---|---|---|
| Patient Safety | Reducing Violence | Services Applicable to | 2016/17 | 2017/18 | Data source |
| | | | | | |
| | | | | | |
| | | | | | |

| | | | | | |
|---|---|---|---|---|---|
| Clinical Effectiveness | **Right Care, Right time in appropriate setting** | Services Applicable to | 2016/17 | 2017/18 | Data source |
| | | | | | |
| | | | | | |
| | | | | | |
| Patient Experience | **Service User and Carers Involvement** | Services Applicable to | 2016/17 | 2017/18 | Data source |
| | | | | | |
| | | | | | |
| | | | | | |
| Staff Experience | **Staff Experience** | Services Applicable to | 2016/17 | 2017/18 | Data source |
| | | | | | |
| | | | | | |
| | | | | | |

***Table seven: Quality Priorities 2018/2019***

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

SLaM is required to be registered with the CQC and its current registration status is registered, without condition. In 2017/2018 SLaM has participated in special reviews or investigations by the Care Quality Commission relating to the following areas; Community Pathway. Following the re-inspection, the overall rating for the Trust remains at 'Good'. The overall rating for the Adult Community Pathway was assessed as 'requires improvement' whilst the specific domains of caring and Well Led were assessed as 'Good'. The current CQC Trust grid rating is outlined below.


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

***Table Eight: Care Quality Commission Inspection Results***

## Key improvements and good practice identified since 2015 – Community


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

| Area of Improvement | Actions undertaken |
|---|---|
| **Risk Assessments** | New Risk assessment audit tool disseminated across the teams with guidance. To be used as a learning tool within supervision with staff. |
| **Care Plans** | Development of a new community care plan using QI methodology. Pilot of the new tool currently underway. |
| **MHA Assessments** | A MHA escalation protocol and staff guidance has been developed and circulated to staff.<br>Regular Police liaison meetings and AMHP service. |
| **Croydon** | Review and clarification of referral criteria |

| | |
|---|---|
| **Assessment and Liaison targets** | Increase in staffing levels<br>Development of a Croydon Assessment and Liaison Duty system screening tool.<br>Quality Improvement programme currently underway with aim of reducing waiting times for assessment. |
| **Training** | Training completion is being regularly monitored and rates are improving. Scrutiny at operational management meetings will ensure consistent accurate completion. |

***Table Nine: CQC Actions***

## Managing Clinical Risk

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

## Audit

## Participation in National Quality Improvement Programmes

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

The National Clinical Audits and National Confidential Inquires that SLaM participated in, and for which data collection was completed during 2017/2018, are listed below. During that period SLaM participated in 100% of national clinical audits 7/7 and 100% of National Confidential Inquiries 1/1 which it was eligible to participate in.

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

- The 5 national, Prescribing Observatory for Mental Health - POMH-UK audits:
  - Use of sodium valproate
  - Prescribing for substance misuse: alcohol detoxification
  - Prescribing antipsychotic medication for people with dementia
  - Monitoring of patients prescribed lithium
  - Rapid tranquilisation
- The Commissioning for Quality and Innovation (CQUIN) 2017/18 Indicator 4a: Improving Physical Healthcare to Reduce Premature Mortality in People with Severe Mental Illness (SMI)
- The national confidential inquiry into suicide and homicide by people with mental illness
- National Clinical Audit of Psychosis

The reports of five national clinical audits were reviewed by the provider in 2017/2018 and SLaM intends to take the following actions to improve the quality of healthcare provided

### National Clinical Audit of Psychosis and CQUIN Indicator 4a: Improving Physical Healthcare to Reduce Premature Mortality in People with Severe Mental Illness (SMI) 2017/18

The Trust participated in data collection and entry onto the NHSE online Webform Portal. In 2017/18 data collected for the National Clinical Audit of Psychosis informed the results for the Trust's CQUIN Target.

The full results from the National Clinical Audit of Psychosis are pending.

## CQUIN Results received in 2017/18

### National CQUIN Indicator 4a: Improving Physical Healthcare to Reduce Premature Mortality in People with Severe Mental Illness (SMI) 2017/18

During September to November 2017, the Trust collected and entered (onto the NHSE online Webform Portal) data for the National CQUIN audit. The Trust was assessed against the following parameters:

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

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

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

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

- they were screened for all six measures listed in the CQUIN guidance during their inpatient stay; and

  where clinically indicated, they were directly provided with, or referred onwards to other services for interventions for each identified problem (with thresholds for intervention being as set out in NICE guidelines).

The data submitted to NHSE is outlined below:

| Standard/ Indicator | CQUIN SLAM I/P Target = 90% | |
|---|---|---|
| | 15/16 | 16/17 |
| **Monitoring of physical health risk** | | |
| Monitoring of smoking | 100% | 100% |
| Monitoring of BMI | 100% | 89% |
| Monitoring of glucose control | 75% | 78% |
| Monitoring of lipids | 75% | 78% |
| Monitoring of blood pressure | 100% | 89% |
| Assessment of substance misuse | 100% | 67% |
| Monitoring of alcohol consumption | 100% | 78% |
| **Intervention offered for identified physical health risks** | | |
| Intervention for smoking | 100% | 78% |
| Intervention for BMI >/= 25kg/m2 | 100% | 75% |
| Intervention for abnormal glucose control | 67% | 86% |
| Intervention for elevated blood pressure | 100% | 88% |
| Intervention for substance misuse | 100% | 100% |
| Intervention for alcohol misuse | 100% | 100% |

***Table Ten: CQUIN Indicator 4a results***

## POMH-UK audits

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

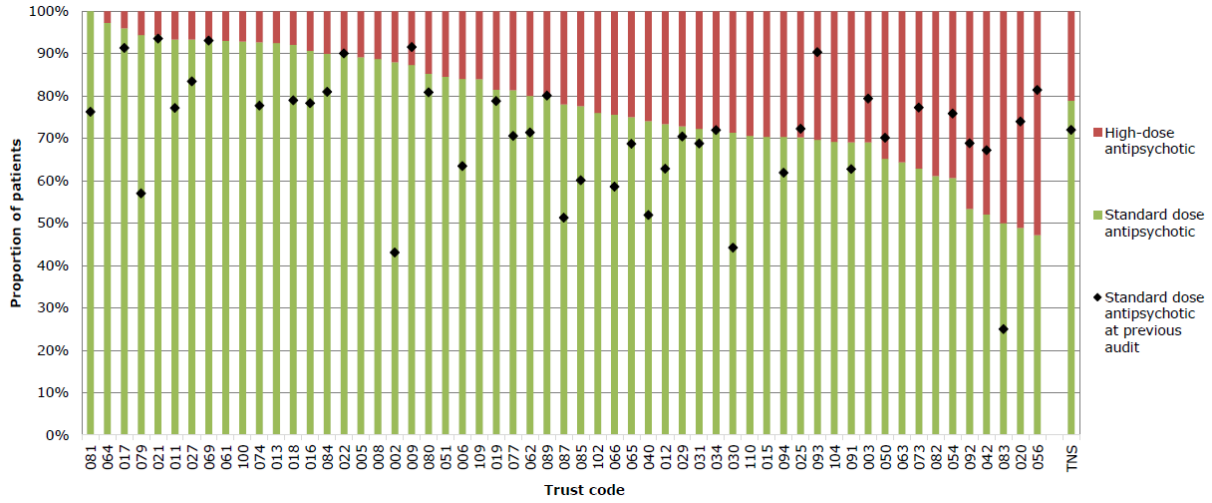
SLAM pharmacy submitted data for the 2017 POMH-UK audits, as required. Below is a summary of the findings from those audits.

Below is a summary of the findings from those audits:

### i) Antipsychotic high dose and polypharmacy on in-patient units

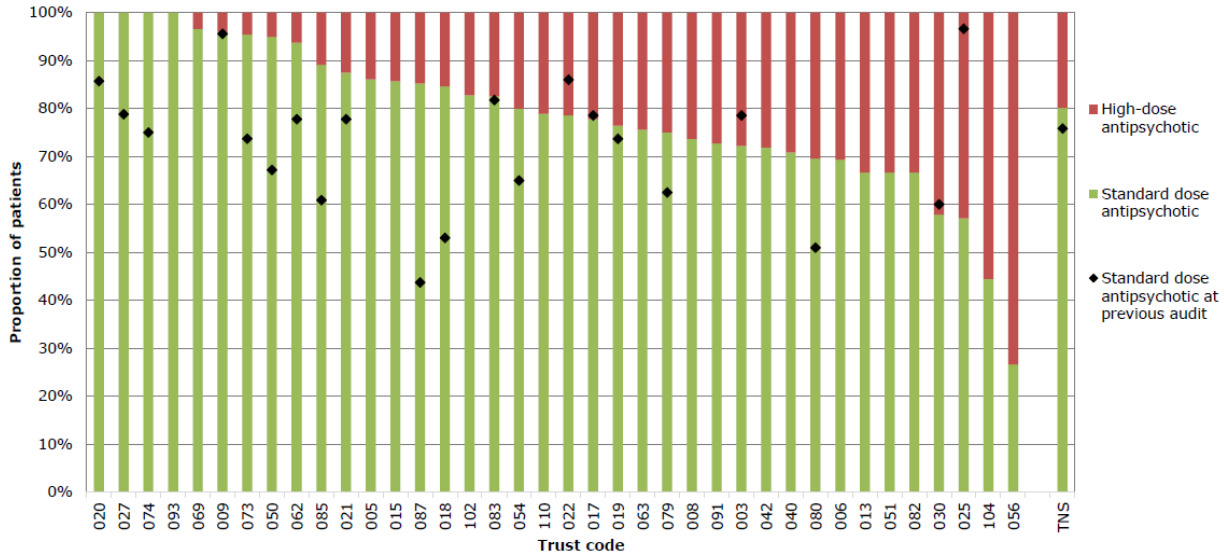
Results of this audit showed that rates of prescribing of high doses and combinations of antipsychotics in SLAM were broadly similar to those reported in the 2012 national audit and lower than in the average national sample.

The graph below shows the proportion of patients in acute and PICU services in SLAM and the national sample who were prescribed a standard and high dose antipsychotic. SLAM is trust T022 and TNS is the average national sample.



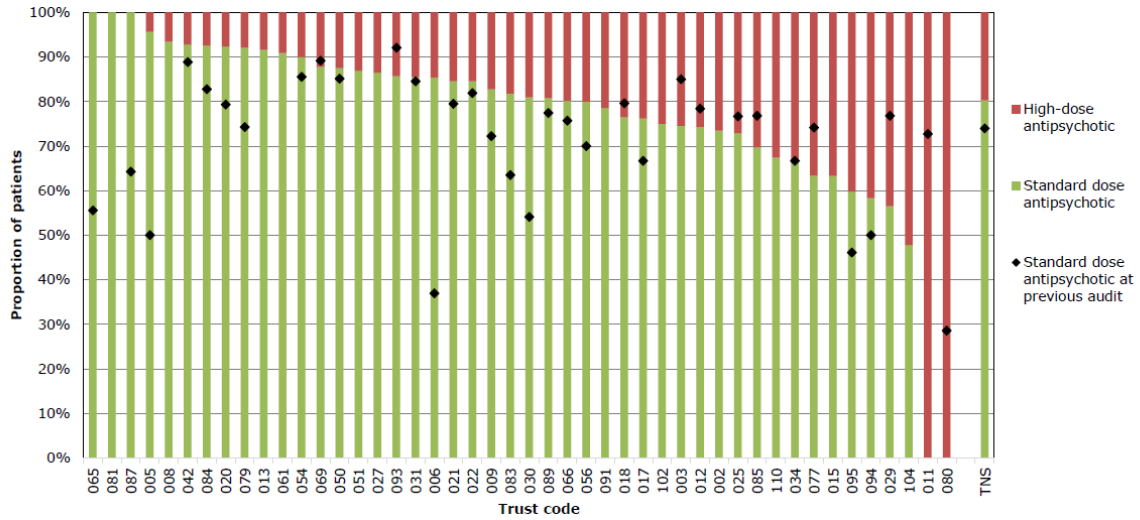

***Graph Four: Antipsychotic dose on in-patient units***

The graph below shows the proportion of patients in rehabilitation and complex care services in SLAM and the national sample who were prescribed a standard and high dose antipsychotic. SLAM is trust T022 and TNS is the average national sample.




***Graph Five: Antipsychotic dose in rehabilitation and complex care services***

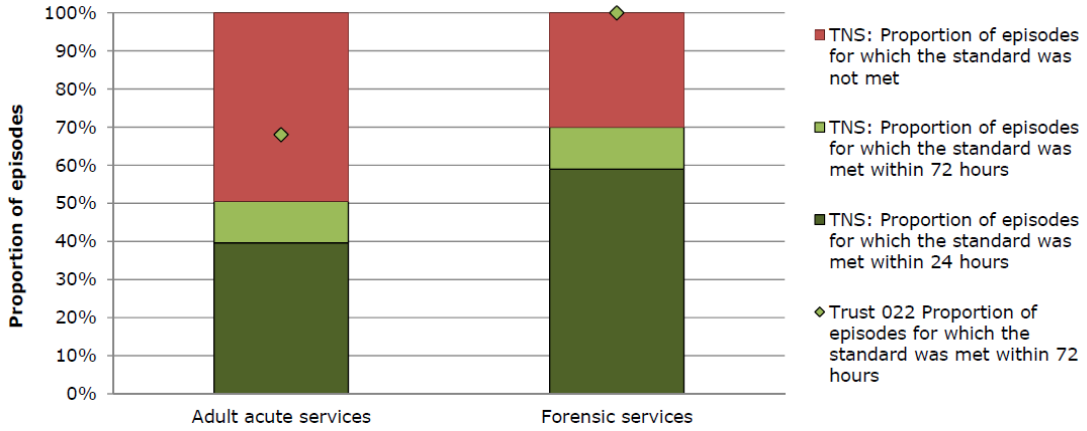
The graph below shows the proportion of patients in forensic services in SLAM and the national sample who were prescribed a standard and high dose antipsychotic. SLAM is trust T022 and TNS is the average national sample




***Graph Six: Antipsychotic dose in forensic services***

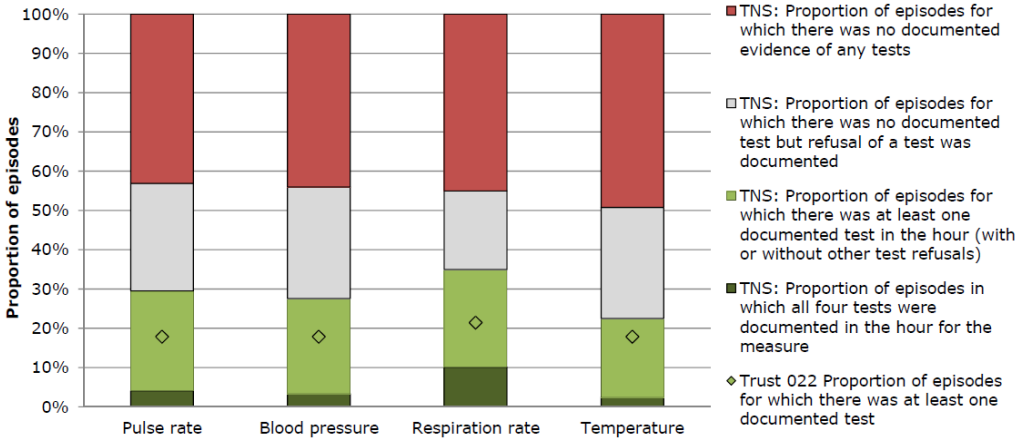
### ii) Rapid tranquilisation - pharmacological management of acutely-disturbed behaviour

Results of this national survey showed that a higher proportion of patients in SLAM than in the average national sample received a prompt debrief following parenteral administration of medication, as shown below.




***Graph Seven: Proportion of patients receiving prompt debrief against standard***

However it is noted that improvements need around the evidence available in ePJS of physical health monitoring in the hour immediately after parenteral medication administration, as shown below.




***Graph Eight: Proportion of patients receiving physical health tests against standard***

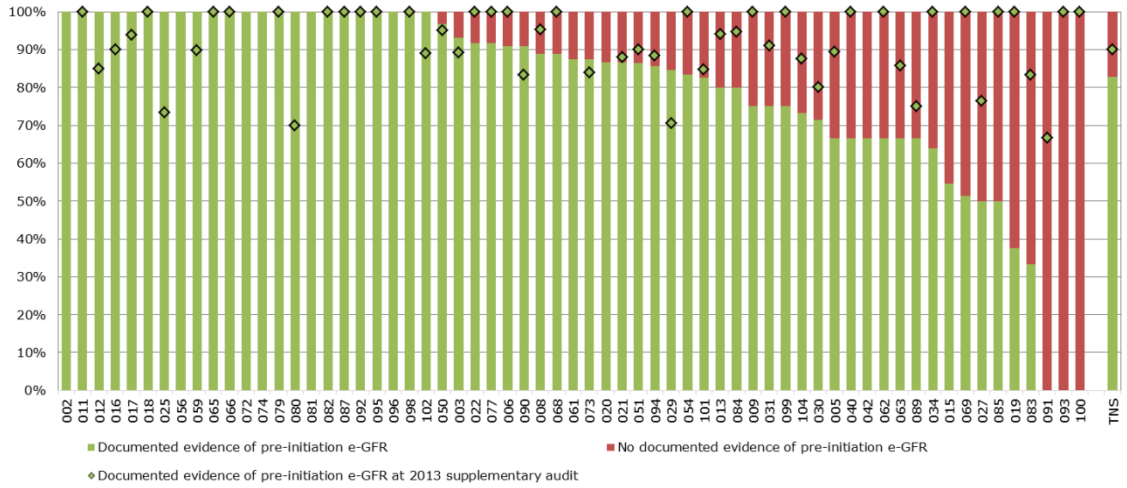
**Actions:** The recommendations for physical health monitoring following RT (including documentation) were included in the medicines bulletin. A link to the trust physical health monitoring guidance was included in the bulletin. The physical health monitoring audit is due to repeated on wards using eOBS.

### iii) Monitoring of patients prescribed lithium

NICE recommends that patients should have their renal and thyroid function assessed before starting lithium. Patients on maintenance treatment should have their plasma lithium level checked every 3 months and their renal and thyroid function tested at least every 6 months.

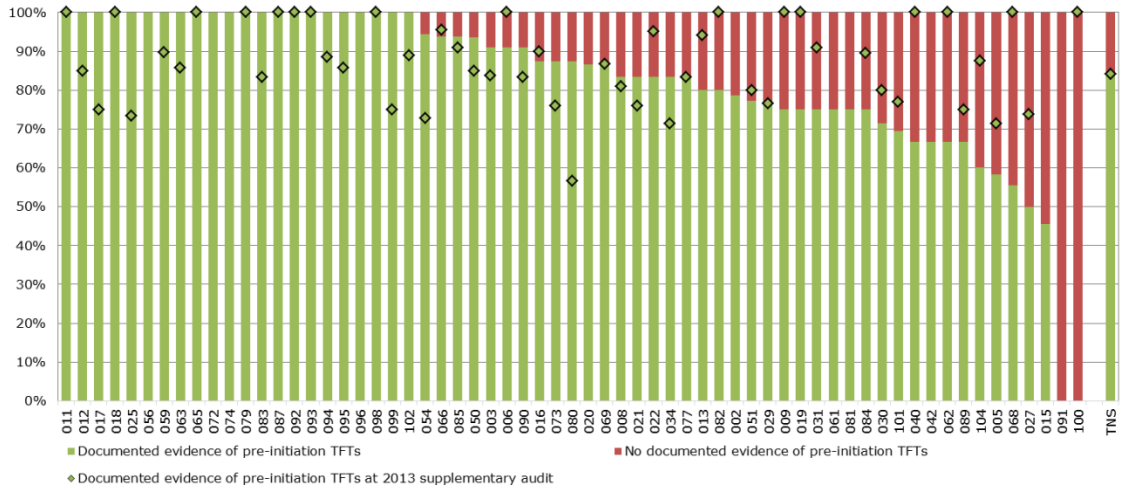
Results of the 2017 national audit of physical health and plasma level monitoring for patients prescribed lithium showed that renal and thyroid function tests were completed before lithium initiation for more patients in SLAM than in the national average, as shown below. SLAM is trust T022 and TNS is the average national sample.

Proportion of patients in SLAM and national sample with evidence of renal function testing before initiating lithium.




***Graph Nine: Proportion of patients with evidence of renal function testing before initiating lithium***

Proportion of patients in SLAM and national sample with evidence of renal function testing before initiating lithium




***Graph Ten: Proportion of patients with evidence of thyroid function testing before initiating lithium***

However, physical health and plasma level monitoring were less evident for patients maintained on lithium in SLAM than in the national average. Lithium plasma level monitoring in SLAM (trust 22) and the national sample (TNS) is shown below.

This re-audit included both in-patients and community patients. The previous audit in 2013 included only in-patients. Physical health monitoring for community patients is undertaken either by their GP or the CMHT. One explanation for poor monitoring in this re-audit may be that results of tests completed by GPs were not readily available on ePJS.

**Actions:** The results and guidance for patient monitoring have been included in the medicines bulletin. For patients who receive lithium from SLAM pharmacy ePJS is checked to determine whether the physical health tests and plasma level monitoring has been completed. Prescribers are reminded of patients with outstanding tests.

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

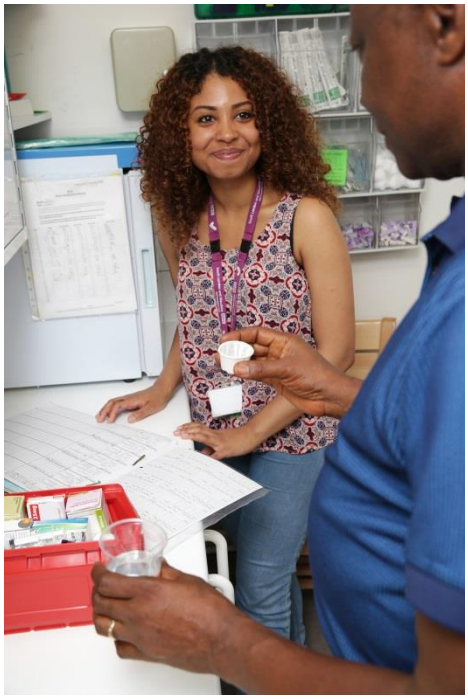
Awaiting information from Michael Holland

## Trust Clinical Audit Programme

The reports of 11 local Trust wide clinical audits have been completed in 2017/18 and where relevant, have been reviewed by the appropriate Trust committees for the development of actions to improve the quality of health care provided. A summary of some of the key audits are outlined below.

### Safeguarding Adults

The audit assessed compliance with the Safeguarding Adults Trust policy regarding good safeguarding practices and the extent of recording within Datix and Trust clinical record systems. A separate audit was completed to assess staff understanding of their safeguarding responsibilities. There was evidence of good documentation compliance and high compliance with staff completion of the Safeguarding Adults training. However, some evidence was not always documented and safeguarding alerts were not always added to the front page of EPJS when there was a current concern. Not all staff members who took part in the survey knew who their CAG safeguarding lead was. Very few also reported that adults at risk had been involved in the safeguarding process when a concern was raised. The audit was presented and discussed at the Trust Safeguarding Adults Committee where recommendations were agreed to address the gaps highlighted.



### Section 132 – Information to Patients detained under the Mental Health Act

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. There was evidence of good compliance. Most service users were aware of their sections and rights, although many had used services and been sectioned previously. The knowledge and distribution of the Department of Health 'Rights Leaflet' was very low. The audit was presented at the Mental Health Act and Law committee. It was agreed the MH Law management team would conduct random monthly audits of S132 compliance and a Quality Improvement project will also be developed to improve MHA compliance at ward level.

**Service User Involvement**

A service evaluation reviewed the service user and carer involvement governance structures at SLaM (Service level and Operational levels). Many staff members and service users reported clarity around why people had been involved in activities and that service users were actively supported to participate and feedback. However the majority of service users felt there could be improvements made to future activities, co-production, and ensuring their views contributed to change. The report was discussed at the Patient and Public Involvement Leads meeting and Service User Involvement Committee where recommendations were agreed to improve service user involvement in future activities.

**Mental Capacity Act – Documentation and Staff Awareness**

Two audits were carried out to assess the Trust's compliance with the Mental Capacity Act Policy, to review documentation and to assess staff awareness of MCA. Just over two thirds of the sample had capacity assessments completed on admission, with the majority completed for medication and treatment. There was little documented evidence of Best Interest meetings and how service users were helped to make decisions as independently as possible. Staff knowledge of the MCA and DoLS and how to record/assess capacity requires improvement, as does staff training. Following discussions at the Mental Health Act and Law Committee, it was agreed that the revised ward round template should be rolled out in 2018, as well as the development of an MCA recording form on EPJS.

## Patients participating in research

The number of patients receiving NHS services provided or sub-contracted by SLaM for the reporting period, 1 April 2017 – 31 March 2018, that were recruited during that period to participate in research approved by a research ethics committee was **To be included…**

## Commissioning for Quality and Innovation (CQUIN)

As last year, TBC of SLaM income in 2017/2018 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 207/18 was TBC.

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

## Hospital Episode Statistics Data – HES

To be included once end of year results available

| | In-Patients – SUS data Apr 2017/ Feb 2018 | Out-patients and Community –MHMDS Apr 2017/ Feb 2018 ( provisional) |
|---|---|---|
| NHS No | | |
| GP Practice code | | |

***Table Eleven: HES***

## Information Governance

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

The Trust Digital Services are continuing to lead the digital transformation programme. The Information Governance Operating Model has been implemented to further improvements around information governance compliance with national standards and key legislation. The GDPR preparedness action plan overseen by the Information Security Committee is well underway for completion before the data protection legislation changes in May 2018. The Information Security Committee is also overseeing the Cyber Security Programme with close engagement and independent reviews by NHS Digital's careCERT and careCERT Assure Programmes. The information governance team updated privacy impact assessment and clearance house processes to improve risk management.

SLaM completed NHS Digital's SCCI1596 Secure Email Standard conformance successfully and @slam.nhs.uk was accredited as a secure email system on 30 September 2017.

Following-on from the CoBIT governance framework training for the Digital Services (IT) staff, the department has gone on to review IT processes in line with this framework.

Following the launch of the Local Care Record in Southwark and Lambeth with trust's partnership, it has expanded to cover Bromley health and care providers. The LCR provides timely and secure sharing of relevant patient information between care professionals to support direct provision of care between primary, secondary and community care services.

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 if they wish to do so.

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

### Payment by Results Clinical Coding

To be included once end of year results available

### Improving Data Quality

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

A new programme was launched which aims to connect the many information systems we use across the Trust. The programme, called Operation SOS: Solving our Systems and thereby a project Team has been set up which will be dedicated to resolving issues such:

- Multiple log-ins and access to business and vital clinical information
- Systems joined- up and linked to enable effective and streamlined working practices.
- Improving access to the right information

The Trust intends to use data to improve the lives of our service users, be a community leader organisation, empower our clinical leaders, service users and management to make informed decisions. Our latest Public Sector Equalities Duty Report can be found here: http://www.slam.nhs.uk/about-us/equality/public-sector-equality-duty

### National indicators 2017/2018

To be included once end of year results available

### Single Oversight Framework

To be included once available

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

To be included once end of year results available

| National Target | SLaM 2015/16 | SLaM 2016/17 | SLaM 2017/18 | National Average 2017/18 | Highest Trust % or Score 2017/18 | Lowest Trust % Score 2017/18 |
|---|---|---|---|---|---|---|
| | 96.99% | 97.1% | | | | |

***Table Twelve: CPA, 7 day follow up***

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

To be included once end of year results available

| | National Target | SLaM 2015/16 | SLaM 2016/17 | SLaM 2017/18 | 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 | | 95.9% | 96.5% | | | | |

***Table Thirteen: Crisis Resolution HTT***

## Readmissions to hospital within 28 days of discharge

To be included once end of year results available

| | SLaM 2015/16 | SLaM 2016/17 | SLaM 2017/18 |
|---|---|---|---|
| Patients readmitted to hospital within 28 days of being discharged | 2.7% | 2.6% | |

***Table Fourteen: Readmissions to Hospital***

## Service Users Experience of Health and Social Care Staff

| | SLaM 2016/2017 | SLaM 2017/2018 | Highest Trust % or Score 16/17 | Lowest Trust % or Score 16/17 |
|---|---|---|---|---|
| **Service users experience of Health and Social Care Staff** *Scores out of 10* | 7.5 | 7.6 | 8.1 | 6.4 |

***Table Fifteen; Ser CPA, 7 day follow up Table ten: Service Users Experience of Health and Social care Staff***

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

The patient survey responses to the question of how users of services found the health and social care staff of the Trust show that in 2017, 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 7.6 with other Trusts performing in a range of 6.4 to 8.1. Two out of three questions had an increase in their scores since 2016 (Q4 and Q5), whilst for Q6 there was a slight decrease from 7.1 to 7.0.

| | | SLaM 2017 score | Lowest trust score | Highest trust score | SLaM (n) | SLaM 2016 | SLaM 2015 | SLaM 2014 |
|---|---|---|---|---|---|---|---|---|
| | **Health and social care workers** | | | | | | | |
| S1 | Section score | 7.6 | 6.4 | 8.1 | | | | |
| Q4 | Did the person or people you saw listen carefully to you? | 8.2 | 7.3 | 8.6 | 198 | 7.9 | 7.9 | 8.5 |
| Q5 | Were you given enough time to discuss your needs and treatment? | 7.5 | 6.8 | 8.2 | 199 | 7.3 | 7.6 | 8.0 |
| Q6 | Did the person or people you saw understand how your mental health needs affect other areas of your life? | 7.0 | 6.2 | 7.8 | 190 | 7.1 | 7.1 | 7.8 |

***Table Sixteen: Survey of people who use community mental health services 2017***

Following a Board Development Session on how the Trust can be an exemplar in terms of service user and carer involvement, it has been agreed that one of the first priorities will be a focus on involvement in own care and this will sit with this work stream. This will be taken forward as part of a review on the Trust's Care Plan Approach (CPA).

## Core Indicators

To be included once end of year results available

| Indicator | SLaM 2017/18 | National Target | National Target Met |
|---|---|---|---|
| 1. Improving access to psychological therapies (IAPT): people with common mental health conditions referred to the IAPT programme will be treated within 6 weeks of referral | | | |
| 2. Improving access to psychological therapies (IAPT): people with common mental health conditions referred to the IAPT programme will be treated within 18 weeks of referral | | | |

| | | | |
|---|---|---|---|
| 3. Care Programme Approach (CPA) 7 Day follow- up | | | |
| 4. Patients requiring acute care who received a gatekeeping assessment by a crisis resolution and home treatment team in line with best practice standards | | | |
| 5. People with a first episode of psychosis begin treatment with a NICE-recommended package of care within 2 weeks of referral | | | |
| 6. Data Completeness, Mental Health: identifiers – NHS Number, Date of Birth, Post Code, Gender, GP code, Commissioner code | | | |
| 7. Data Completeness, Mental Health: outcomes (for patients on CPA) – accommodation and employment status | | | |

***Table Seventeen: Core Indicators***

## Patient safety incidents resulting in severe harm or death

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

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

| NRLS Data Q3-Q4 16/17 | SLAM 16/17 | Average for Mental Health Trusts | Highest Trust % or Score 15/16 | Lowest Trust % or Score 15/16 |
|---|---|---|---|---|
| Reported Incidents per 1000 bed days | 19.69 | 46.04% | 88.21 | 11.17 |
| Percentage of incidents resulting in severe harm | 0.5% | 0.4% | 1.8% | 0.0% |
| Percentage of incidents reported as deaths | 0.2% | 1.0% | 3.8% | 0.0% |

| NRLS Data Q1-Q2 17/18 | SLAM 16/17 | Average for Mental | Highest Trust % or | Lowest Trust % or |
|---|---|---|---|---|

| | | Health Trusts | Score 16/17 | Score 16/17 |
|---|---|---|---|---|
| Reported Incidents per 1000 bed days | | 51.5 | 126.47 | 16 |
| Percentage of incidents resulting in severe harm | 0.5% | 0.3% | 2.0% | 0.0% |
| Percentage of incidents reported as deaths | 0.2% | 0.9% | 3.4% | 0.0% |

***Table eighteen: NRLS (National Reporting and Learning Service) Data***

## Learning from Deaths

The number of its patients who have died during the reporting period, including a quarterly breakdown of the annual figure.

During 2017/18 565 of SLaM patients died. This comprised the following number of deaths which occurred in each quarter of that reporting period: 149 in the first quarter; 100 in the second quarter; 140 in the third quarter; 176 in the fourth quarter.

354 case record reviews and 60 investigations have been carried out in relation to 565 of the deaths.

In 37 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 2017/18 | Q2 2017/18 | Q3 2017/18 | Q4 2017/18 |
|---|---|---|---|---|
| | 113 | 84 | 102 | 78 |

18 representing 3.19% of the patient deaths during the reporting period are judged to be more likely than not to have been due to problems in the care provided to the patient.

In relation to each quarter, this consisted of:

| Q1 2017/18 | Q2 2017/18 | Q3 2017/18 | Q4 2017/18 |
|---|---|---|---|
| 5 representing 3.36% | # representing 7% | 2 representing 1.42% | 4 representing 2.27% |

These numbers have been estimated using adapted versions, used with permission, of two frameworks the Mazars framework with 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. 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.

SLaM 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 with limited details on the physical health needs. Where care plans and risk management plans were completed these were not always individualised or specific enough.

The Trust identified communication as a key learning point with GPs including the communication of physical health care plans and coordinated care between services.

Several reviews identified that the service users did not engage well with services for both their physical and psychiatric care.

It was highlighted that a number of the reviews demonstrated the provision of good quality care with compassionate and caring staff.

### Actions taken

The Trust has taken the following actions during 2017/18. Inpatient services have physical health care plans are part of the core care plan for patients. Services have been reminded of the support available to them in compiling these including clinical nurse specialists, modern matrons and the Trust's Nurse Consultant for Physical Health and Wellbeing.

The Trust completed a mortality audit in 2017/18 and will be repeating this in 2018/19. This identified improvements in the interface between mortality and the physical health strategy.

The Trust's Medical Director and Quality Improvement Team are reviewing the Mortality Review Driver Diagram to align with the Trust's physical health strategy and committee. Learning from mortality reviews is shared through the Trust's Medical Director.

The Trust continues to assess the impact of the actions highlighted above.

### Duty of Candour 2016/2017

In October 2017, the Trust's Clinical Audit and Effectiveness team undertook a Duty of Candour audit identifying several learning points. The audit was taken to the Trust's Quality Committee and presented to the four borough clinical quality review group to share learning and identify any further recommendations. The following key learning points were identified in the audit updates to Trust SI report template, QI project to be undertaken with CAGs to strengthen understanding, revision of the Duty of Candour policy including – guidance for staff, template letters and external website reference, a communication campaign, training and updates to the incident reporting system to capture Duty of Candour more consistently. The Director of Nursing commenced the Serious Incident Review Group which has increased the scrutiny and oversight of Duty of Candour for serious incident investigations.

# Annex 1

NHS Croydon CCG, NHS Lambeth CCG, NHS Lewisham CCG and NHS Southwark CCG Joint Statement on South London and Maudsley NHS Foundation Trust's Quality Account 2016/17

Comments from Overview and Scrutiny Committee, London Borough of Lambeth

Governors' reply to Quality Accounts 2017/18- Once Complete

South London and Maudsley NHS Foundation Trust (SLaM) Quality Accounts 2017/18 Response from local Healthwatch- Once received

## Annex 2

Statement of Directors' Responsibilities In Respect of the Quality Report- Once Complete- May 2018

## Glossary

TO ADD- once report complete