South London and Maudsley NHS Foundation Trust

Quality Account 2014/15
Part 1:

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

The annual quality account report is an important way for the Trust to report on quality and show improvements in the services we deliver to local communities and stakeholders. This year has seen the development of the SLaM five year Quality Strategy much of which has been reflected in this year’s chosen priorities.

The Strategy complements the Trust’s five year Strategic Plan and reflects national and local priorities as well as expectations of service users, carers, staff, commissioners and regulators.

We have welcomed the involvement and feedback made by our local stakeholders during the development of this quality account. We are once again also grateful for the valuable contribution made by our Foundation Trust’s Council of Governors to this report, through its quality sub-committee.

It is disappointing that we did not meet all the targets we set last year and subsequently some of these have been rolled over to this year, where they have continued to be a key priority for both the Trust and our stakeholders during the consultation process. I am however, pleased to note the improvement in areas such as physical healthcare screening and we build on the work carried out in 2014/2015. Where priorities have not been rolled over but fell short of reaching their target they will continue to be monitored throughout the year for improvement in these areas.

This year we have worked closely with our local commissioners at the four Borough Clinical Quality Review Group and at other meetings in ensuring that the quality of services we provide is of a high standard and ensure quality improvement processes are in place where needed. We are pleased that the commissioners feel we have responded positively to their feedback and questions when sought.

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

![Signature]

**Dr Matthew Patrick**  
Chief Executive Officer
A summary of successes and developments in 2014/2015

- Funding has been agreed and we will be implementing a Crisis line in 2015/2016 which will be operated 24/7 by mental health professionals. They will offer counselling and advice to callers of the service which will also include signposting. Part of this implementation will include the development of new publicity materials which will include crisis leaflets and posters being made available to both SLaM service users and the general public.

- In September 2014, the Eating Disorders Unit launched FREED (First Episode and Rapid Early Intervention for Eating Disorders) service - a novel service for all patients (across eating disorder diagnoses) aged 18-25 with a recent onset eating disorder (within 3 years). We consider early intervention as essential to prevent distress, chronicity, disability and mortality associated with eating disorders.

- The Trust successfully became a totally smoke free environment for patients and staff in October 2014. This involved improving the availability of advice and support and nicotine replacement therapy available to patients who smoke, both in the community and when admitted to hospital.

- This year has seen the further development of sharing information and understanding mental health with the general public at London train stations. The stall is facilitated by Slam Service Users/Volunteers and staff from the Clinical Audit Team. This has been in liaison with the British transport police. The stall is held regularly to promote specific mental health days such as Time to Change and ‘Blue Monday’ in January. Due to the success of this project initially at Waterloo Train station and very positive feedback from the general public at Waterloo station, it is now being rolled out at other major train stations including London Bridge.

- The Recovery College which offers a wide range of courses and workshops which are designed to help people recovering from mental illness become experts in their own recovery was further developed this year. There were approximately 44 courses running, with 355 registered students who booked 1550 course places. There were 68 trainers who were both staff and people with lived experience. Attendees included 70% service users, 17% staff and 13% carers/supporters. The courses were held in nine different venues across all boroughs Trust-wide. There was both national and international interest in the college including a visit from the World Health Organisation; Mental Health Service Policy and Service Development Team.

- This year has seen the growth in the number of people who have registered to become a volunteer within SLaM. The profiles of the people who have registered are 45% of people with lived experience and many people who have volunteered with us have gone on to paid employment and further education. This year saw a small growth in the number of paid peer workers which we hope to develop further in 2015/2016.

- This year our team in the Centre for Mental Health Simulation has further developed the simulation courses following funding from Health Education South London (HESL) and charitable foundations. To date there have been twenty-two inter-professional simulation courses aimed at improving psychiatric patient care, safety and experience. These have been offered to both mental health and acute trusts across the whole of South London.

- A number of the courses have been developed specifically with nursing practice in mind. These include in-situ courses on the management of psychiatric and medical emergencies for inpatient staff, and community care coordinator training. Some of these courses have now been externally purchased.
This year saw £1 million being awarded to the Trust by the NHS England Nursing Tech Fund to roll out E-obs across the Trust. An electronic device that enables staff to capture mental health observations in real time, E-obs was originally developed by staff on the NAU. The Behavioural and Developmental Psychiatry CAG has offered to be the pilot setting for this exciting development.

This year SLaM won a British Medical Association (BMA) Patient Information Award. This was the special award for Self-Care Resource, for the Physical Health and Wellbeing Handbook for Service Users and Carers.

...and what we can do better.

- It was disappointing that we did not meet all the targets we set last year and subsequently some of these have been rolled over to this year following feedback on this year’s priorities. Where priorities have not been rolled over this year but fell short of reaching their target they will continue to be monitored throughout the year.

- Violence and aggression still remains a threat to the safety of patients and staff on our in-patient units. In 2015/16 following the funding by the Health Foundation we will be doing more to help patients feel safer, by continuing to press forward with our violence reduction strategy which includes a range of evidence based interventions that are being embedded into practice.

- Patient survey results and other stakeholder feedback continue to indicate that patients want information on how to access the support and advice they need quickly when in a crisis or emergency. As outlined above we will be taking steps to improve the information available and support with the new proposed crisis line.

- Although there was an improvement in the routine screening of patients with serious diseases such as diabetes and coronary artery disease, this needs to be improved further. Utilising the E-obs electronic device outlined above should help with this.

- We need to further improve the quality of our in-patient environments as this is a recurring theme of CQC inspections in 2014/15. The improved environments of our wards are part of the ongoing refurbishment programme.

All these have been translated into quality priorities for 2014/15.
2.1 Our priorities for improvement for 2015/2016

Over the past year we have listened to feedback from service users, their families and carers, our staff, as well as commissioners and regulators. This has helped us to identify our future priorities.

This process of gathering feedback has included:

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

In addition we have been mindful of the work that we have done so far to improve the quality of our services and our desire to build upon what has been done so far.

In consulting and agreeing on our quality priorities for next year we have taken into account a number of national frameworks and guidance and local priorities on quality including:

- Trust 5 year Quality Strategy
- Positive and Proactive Care: reducing the need for restrictive interventions
- The national mental health strategy - ‘No Health Without Mental Health’
- The Francis Report into the failings at Mid Staffordshire NHT FT, and the government response to the Francis report
- The Commissioning for Quality and Innovation framework [CQUIN]
- Quality schedules in our contracts with Clinical Commissioning Groups
- The Trust Equality Objectives 2013-16

The priorities for 2015/2016 which are set out in this report have been arranged under the three broad headings which, put together, provide the national definition of quality in NHS services: patient safety, clinical effectiveness and patient experience.

Progress on achievement of these priorities will be reported on in next year’s Quality Accounts.
## Our Quality Priorities for 2015/16

<table>
<thead>
<tr>
<th>Quality Priority</th>
<th>This priority continues from previous years</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>1. Patient Safety Priority</strong></td>
<td></td>
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<tr>
<td><strong>Quality Priority</strong></td>
<td>Violence and aggression on in-patient wards continues to be a challenge to ensuring that all patients benefit from a safe and therapeutic stay in hospital. Our quality priority this year is to work to <strong>increase the number of patients who feel safer when in our hospitals</strong>. Currently the Trust is developing a Violence Reduction Strategy which will focus on reducing violence against patients and staff. The strategy will incorporate guidance from the Department of Health - Positive and Proactive Care.</td>
</tr>
<tr>
<td><strong>Target</strong></td>
<td>Our target is to Increase the number of people who when asked say they feel safe in our services.</td>
</tr>
<tr>
<td><strong>Target:</strong></td>
<td>&gt;90% of patients feel safe.</td>
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<tr>
<td><strong>Baseline figure:</strong></td>
<td>81% in 2014 / 2015.</td>
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<tr>
<td><strong>Measure</strong></td>
<td>We will measure this by asking the questions in our patient surveys; “Do you feel safe?” The question will also be asked as an element of the MH safety thermometer. We will also measure the number of teams who are actively adopting the Care Delivery system.</td>
</tr>
<tr>
<td><strong>How we will achieve this</strong></td>
<td>Following recent funding by the National Health Foundation, we will continue to push forward with our violence reduction strategy. We will adopt the care delivery system (CDS) in all in-patient areas over the next two years to reduce violence and aggression on in-patient units. The first cohort will start the training programme in September 2015.</td>
</tr>
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</table>
## 2. Patient Safety Priority

<table>
<thead>
<tr>
<th>Quality Priority</th>
<th>This is a new priority</th>
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</table>
| **Quality Priority**                                                            | We will make it *easier for patients to access help in a crisis.*  
Patients should know where to access help at times of crisis. This was a recurring theme during the consultation process from patients, carers and other stakeholders. This has also been raised as an issue by patients in the National survey. |
| **Target**                                                                      | Target is that at least >75% of all community patients asked will respond positively to this survey question, *'Do you know what to do in an emergency mental health situation'*.  
**Baseline figure:** 73% 2014 / 2015 Patient survey |
| **Measure**                                                                     | This will be measured via surveys. |
| **How we will achieve this**                                                    | New crisis line will be implemented in Spring 2015/2016.  
This will be a 24/7 crisis line staffed by qualified MH professionals who will be able to offer on the spot crisis counselling and advice. They will also be able to offer signposting to a range of other organisations and range of services available.  
Posters and leaflets advertising this new service will be distributed widely across the 4 boroughs. |
### 3. Clinical Effectiveness

**Quality Priority**

We will continue to improve our screening of patients for cardiovascular and metabolic disease. This is a NICE guideline requirement, and a continuation of the CQUIN work during 2014/15.

The CQUIN target will include patients with psychoses and community patients in Early Intervention psychosis teams.

- This is line with the Trust 5 year Quality Strategy.

**Target**

90% of patients audited during the period (inpatients) or for 80% of (community EIP), patients audited during the period the Trust has undertaken an assessment of each of the following key cardio metabolic parameters, with the results recorded in the patient's notes/care plan/discharge documentation as appropriate, together with a record of associated interventions (e.g., smoking cessation programme, lifestyle interventions, medication review, treatment according to NICE guidelines and/or onward referral to another clinician for assessment, diagnosis, and treatment).

**The parameters are:**

- Smoking status;
- Lifestyle (including exercise, diet alcohol and drugs);
- Body Mass Index;
- Blood pressure;
- Glucose regulation (HbA1c or fasting glucose or random glucose as appropriate);
- Blood lipids.

Provider supplies evidence of systematic feedback on performance to clinical teams.

**Measure**

This will be measured via external national audit which are similar processes in 14/15.

**How we will achieve this**

We will build on work carried out in 14/15. We have gained resources to implement an electronic observation system (E-OBS) which will enable clinical staff to record and monitor physical observations both efficiently and effectively. This will involve a system of escalation for action.
### 4. Patient Experience

**Quality Priority**

It is important that patients identify and achieve outcomes that matter to them, and that users are at the centre of their own care. We will ensure patients are involved in their care and ensure patients understand their care plans in both in-patient and community settings. We will ask via the patient survey ‘Do you feel involved in your care’?

- This is line with the Trust 5 year Quality Strategy.

**Target**

Our target is to increase the number >83.5% of people who when asked will say they feel involved in their care.

**Baseline figure:** 83.5%.

**Measure**

Patient survey.

**How we will achieve this**

By building on work in 2014/2015 around the CQUIN target regarding the successful implementation of the Recovery and Support plan and further training and publicity for clinical staff, and feedback of performance throughout the year.
### 5. Patient Experience Priority

| **Quality Priority** | We will recognise the role of the carer. This issue has been raised by carers and services in feedback such as complaints and serious incidents. This is in line with the Trust’s 5 year Quality strategy. **Where there is an identified carer, they should have been offered a carer’s assessment.** Following on from the assessment the carer is entitled to their own care plan, which is given to them and implemented in discussion with them (Care Act 2014; Section 10). The care plan is a critical part of the carers needs assessment.  
  
  NICE Psychosis and Schizophrenia in Adults  
  - This is line with the Trust 5 year Quality Strategy. |

| **Target** | Our target is 30% of identified carers who state they have been offered a carer’s assessment from the 2014/2015 Trust audit. Over the course of five years as part of our five year strategy we would hope to build on this target further.  
  
  **Baseline figure:** 20% |

| **Measure** | We will measure this by Trust Audit. |

| **How we will achieve this** | We have developed a new Carers Strategy which will come into force from June 2015. This will be launched at the Trust carers’ annual event in the summer. The strategy sets out clear plans to recognise, support and inform carers. |
### 6. Patient Experience Priority

**Quality Priority**

We will continue to **improve the quality of the environments within our in-patient wards**. This has been highlighted as an issue with CQC inspections with some of our in-patient units in 2014/15.

**Target**

Improvement in environmental PLACE audit scores from 2014/2015 to >95%.

**Measure**

PLACE - Patient Led Assessments of Care Environments. We will also monitor the progress against the plan to redecorate and refurbish wards.

**How we will achieve this**

Continued monitoring through Hotel Services ‘Spot Light reports’. We will also continue our refurbishment programme which will coincide and complement the ASCOM system (upgraded Alarm system: 3 year programme) and Anti-ligature works to all inpatient wards.

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### 7. Patient Safety Priority

**Quality Priority**

The effective use of risk assessments in patient care has been identified in Serious Incidents and feedback from commissioners as an area for improvement. This year we **will aim to improve how full risk assessments for Inpatients and Community patients on CPA are documented and used to inform decisions on patient care**. We aim to ensure there is a robust approach to using risk assessments in the day to day work within the Trust.

**Target**

75% of Inpatients and Community Patients on CPA will have a full documented risk assessment.

**Baseline figure**: >65%.

**Measure**

We will measure this through audit in Q4/16.

**How we will achieve this**

Review of Risk Assessment policy which will include an implementation plan. The development of Electronic Patient Journey system to support staff in utilising relevant documentation (EPJS).
### 8. Clinical Effectiveness Priority

| Quality Priority | The Adult Mental Health (AMH) model provides an enhanced multi-intervention service into the community.
|                  | 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 numerator 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.

**This year we will reduce the number of people supported by HTT who then require an admission.**

| Target | No more than 15% of people who have been supported by HTT to then require an Inpatient admission in services where the AMH model has been established.
|        | **Baseline figure:** >17%.

| Measure | We will measure this by extracting data on patient admissions from our electronic records system in Q4/2016.

<p>| How we will achieve this | Further development of the AMH model. |</p>
<table>
<thead>
<tr>
<th><strong>9. Clinical Effectiveness Priority</strong></th>
<th>This is a new priority</th>
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<tbody>
<tr>
<td><strong>Quality Priority</strong></td>
<td>Co-morbid substance use is very common in people with mental health problems (30-50% and in some groups even higher), so working with people with dual disorders is core to modern mental health care. In order to maintain the safety of patients and others with whom they have contact, and to offer appropriate interventions to support recovery, best practice in the assessment of substance use is required (see eg DH 2002, 2006, 2008, NICE 2011). <strong>We will increase the frequency with which people in SLaM services are asked about their use of alcohol and non-prescribed drugs so that we can work more effectively with them to maintain their safety and plan recovery.</strong></td>
</tr>
<tr>
<td><strong>Target</strong></td>
<td>50% of service users from our adult acute Inpatient and Adult Community teams will have both a drug and alcohol assessment and an AUDIT (Alcohol Use Disorders Identification Test) completed.</td>
</tr>
<tr>
<td><strong>Measure</strong></td>
<td>This will be measured by an audit regarding the completion of both the AUDIT (Alcohol Use Disorders Identification Test - alcohol screening tool) and the Drug and Alcohol Assessment. <strong>Baseline:</strong> From 2014/2015 Trust audit 18% AUDIT 33% Drug and Alcohol Assessment</td>
</tr>
<tr>
<td><strong>How we will achieve this</strong></td>
<td>Each CAG (involved) to have a strategy. <strong>Likely to include:</strong> - Team training for AMH PR teams - Training for AMH A&amp;L teams - Team DD leads prioritise promotion of alcohol and drug assessment as objective (using local mechanisms for delivery of training and audit)</td>
</tr>
</tbody>
</table>
2.2.2 Participation in National Quality Improvement Programmes

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

During 2014/15, four national clinical audits and two national confidential enquiries covered NHS services that the South London and Maudsley NHS Foundation Trust provides.

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

The national clinical audits and national confidential enquiries that SLaM was eligible to participate in during 2014/15 are listed below:

- The 4 national, Prescribing Observatory for Mental Health - POMH-UK audits:
  i. Prescribing for Alcohol Detoxification
  ii. Prescribing for Patients with Personality Disorder
  iii. Prescribing for Children and Adolescents
  iv. Prescribing of Anti Dementia Drugs
- The national confidential enquiry into suicide and homicide by people with mental illness
- The national confidential inquiry into maternal and child deaths

The national clinical audits that SLAM participated in, for which data collection was completed during 2014/15, are listed below.

POMH-UK audits

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

SLAM pharmacy has collected and submitted data for the 2014-15 POMH-UK audits, as required.

i. Prescribing for Alcohol Detoxification
ii. Prescribing for Patients with Personality Disorder
iii. Prescribing for Children and Adolescents
iv. Prescribing of Anti Dementia Drugs

Below is a summary of the findings from those audits:

i) Prescribing for Alcohol Detoxification

Results of this baseline audit in 2014 showed that SLaM was comparable to the average national sample in its prescribing for alcohol detoxification.

ii) Prescribing for Patients with Personality Disorder

Results of the 2014 re-audit showed an improvement in the prescribing for patients in SLaM with a personality disorder. It is recommended that reasons for prescribing a psychotropic be clearly documented in patient notes and that treatment be limited to 4 weeks at any time.
iii) Prescribing for Children and Adolescents

Children and adolescents prescribed an antipsychotic should have the reason for prescription clearly documented in their notes. In addition, physical health should be monitored before starting an anti-psychotic and at least every 6 months during treatment.

All patients in this second re-audit of anti-psychotic prescribing had the reason for prescribing an anti-psychotic documented in their notes. Physical health monitoring was better in SLaM than in the average national sample.

iv) Prescribing of Anti Dementia Drugs

Patients prescribed anti-dementia drugs should have an assessment of their cognitive function and cardiovascular risk before treatment is initiated. The effects of medication should be reviewed during maintenance treatment. Overall, in this baseline audit more patients in SLaM than in the average national sample had pre-treatment assessments as recommended. However, performance in SLaM was slightly below the national average for patients on maintenance treatment.

Results received in 2014/15 from data collected in 2013/14

The National Audit of Schizophrenia

The National Audit of Schizophrenia published its second report in October 2014 and the results were reviewed with the Psychosis CAG Executive team in January 2015. A random sample of 200 adult service users with a diagnosis of schizophrenia or schizoaffective disorder under the care of a community mental health team for at least 12 months were sent a service user questionnaire. Of these, 100 were randomly selected to be included also in the clinician questionnaire of the audit of practice.

The number of returns received by SLaM were as follows:

<table>
<thead>
<tr>
<th></th>
<th>Number of cases submitted by SLaM</th>
<th>Number of cases required</th>
<th>Percentage Returned</th>
</tr>
</thead>
<tbody>
<tr>
<td>Clinician questionnaire</td>
<td>89</td>
<td>100</td>
<td>89%</td>
</tr>
<tr>
<td>Service-user questionnaire</td>
<td>70</td>
<td>N/A</td>
<td>N/A</td>
</tr>
<tr>
<td>Carer Survey</td>
<td>22</td>
<td>N/A</td>
<td>N/A</td>
</tr>
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</table>
Areas where we performed better when compared to the national sample mainly focused on prescribing and include:

i. The service user is currently only prescribed a single anti-psychotic drug (unless they are in a short period of overlap while changing medication or because clozapine is co-prescribed with a second anti-psychotic) and a rationale for this has been documented.

SLaM Score: 2% vs. Total National Sample: 11%

ii) The current total daily dose of anti-psychotic drug does not exceed the upper limit of the dose range recommended by the BNF. If it does, the rationale for this has been documented.

SLaM Score: 2% vs. Total National Sample: 10%

iii) The service user was involved in deciding which anti-psychotic was to be prescribed, after discussion of the benefits and potential side-effects.

SLaM Score: 80% vs. Total National Sample: 71%

In terms of service user experience, we performed the same as the national sample

iv) Service users report that their experience of care over the past 12 months has been positive

SLaM Score: 88% vs. Total National Sample: 88%

v) Service users report positive outcomes from the care they have received over the past 12 months

SLaM Score: 86% vs. Total National Sample: 86%

Three key areas for improvement were highlighted where the Trust did less well compared to the national sample:

Physical Health

vi) The following physical health indicators have been monitored within the past 12 months: i. History of cardiovascular disease, diabetes, hypertension or dyslipidaemia in members of the service user’s family. ii. Use of tobacco. iii. Body mass index (BMI) iv. Blood glucose control v. Blood lipids vi. Blood pressure. (N.B family history excluded from results)

SLaM Score: 26% vs. Total National Sample: 33%

Psychological Therapies

vii) CBT has been offered to all service users (service user questionnaire results)

SLaM Score: 14% vs. Total National Sample: 18%

viii) Family Intervention has been offered to all service users who are in close contact with their families.

SLaM Score: 9% vs. Total National Sample: 19%

Crisis Access

ix) Each service user knows how to contact services if in crisis (service user questionnaire results)

SLaM Score: 56% vs. Total National Sample: 74%
Trust Clinical Audit Programme

The reports of 33 local Trust wide clinical audits were reviewed by our Quality Governance Committee in 2014/15 and a number of actions have been taken to improve the quality of health care provided.

Here are descriptions of four of them:

**Psychosis Co-existing with Substance Misuse Information Audit.**

Following the audit on the availability of substance misuse information on inpatient wards (standards from NICE and Trust Policy), the Trust leaflets: “Drug and Alcohol Use Information for Service Users” and “Drug and Alcohol Use Information for Carers” were revised and details sent to ward managers and uploaded to the Trust Dual Diagnosis intranet site. A summary of the audit findings and recommendations to teams was also circulated to ward managers and published in SLAM e-news: encouraging teams to provide service users with alcohol/substance misuse information. The summary also provided hyperlinks to key documents with information on: which dual diagnosis resources to make available to service users, how to get them and guidance on the process for disseminating drug alerts. It was also requested that all teams allocate a dual diagnosis lead. The audit and actions were fed-back to Psychosis and Psychological Medicine CAG Governance meetings.

**What Lessons are Being Learnt from Complaints and Serious Incidents in SLAM?**

Following the audit which themed actions resulting from serious incidents and complaints, the clinical audit work plan was revised to include audits on the prominent action areas: Carers (report complete), Clinical Risk Assessment and Management of Harm (report complete) and Pressure Ulcers (underway). New fields were also added to Datix in order for the policy area to be included in future complaint/serious incident entries. Specific actions themed under a particular heading were sent to the relevant policy/topic lead suggesting that the actions were considered when reviewing/developing policies and undertaking quality improvement. As training was a top theme, training actions were sent to the Deputy Director of Education and Development and the Head of Library and E-learning Services for their consultation when developing training programmes. Reminders were sent to CAGs regarding the implementation of actions preceding a serious incident or complaint. These and other recommendations will be evaluated in a re-audit in 2015-16.

**Mortality Review of SLAM Patients Over a 5 Year Period (April 2008 – March 2013)**

Following the audits completion in 2013/14, improvement work was carried out in Q1 of 2014/15. ePJS and Datix guidance were produced for recording the death of a patient. The suicide prevention strategy was reviewed with the MAP CAG. SLAM has participated in the LSLC national CQUIN on physical healthcare and ongoing improvement work is taking place in the Contracts Team. The CQUIN will be rolling over to 2015/16. CAG Leads have been encouraged to maintain accurate records regarding the recording of deaths on Datix.

**Being Open and Duty of Candour**

Following the audit several guidance documents were produced regarding the Duty of Candour and uploaded to the Patient Safety intranet site. These documents are also sent as part of the serious incident commissioning emails. Extra Datix fields and prompts regarding the Duty of Candour were produced and the Being Open and Duty of Candour Policy was revised and circulated to staff. An item was produced for SLAM e-news in order to prompt and inform staff of the Duty of Candour.

**Level of Risk of Venous Thromboembolism (VTE) in SLAM’s Inpatient Settings**

Following the VTE audit, a new risk assessment tool was launched on ePJS with the help of the National Thrombosis Centre (KHP). Meetings have been taking place with the National Thrombosis Centre for discussion of policy development and further research into VTE prevention. A patient leaflet has been drafted.
Patients participating in research
The number of patients receiving NHS services provided or sub-contracted by the South London and Maudsley NHS Foundation Trust (SLaM) for the reporting period, 1 April 2014 - 31 March 2015, that were recruited during that period to participate in research approved by a research ethics committee was 4236.

Commissioning for Quality and Innovation (CQUIN)
2.5 % of SLaM income in 2014/15 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 2014/15 was £5.8m.

Care Quality Commission CQC
SLaM is required to be registered with the CQC and its current registration status is registered, without condition. The CQC has not taken enforcement action against SLaM during the period 2014/15.

SLaM has participated in a special review relating to the following area during 2014/15. A thematic review by the CQC took place on the 6th and 7th January 2015. The aim of this review was to assess people's experience of mental health crisis care provided within the local authority area (Lambeth). The five areas that underpinned the CQC review which needed to be evidenced were as follows:

In particular they used the above areas for people who experience a mental health crisis and who go to:
- Accident and Emergency departments with a particular focus on people who self-harm
- Require access and support from specialist mental health services
- Are detained under section 136 of the MHA

The review looked in particular at:
- Assessing the quality of a services’ response to a person experiencing a mental health crisis
- Looking at how different areas organisations and agencies work together to provide an effective response with a local area.

In summary the verbal feedback given by the inspectors stated there had been evidence of:
‘Collaboration, innovation, awareness and willingness to improve services and the experience of service users’. They identified a wide range of areas of good practice and a few areas that could be further improved. They found that the care pathways were clear for people who experienced mental health crisis and presented to accident and emergency. People were assessed within a timely manner and there were clearly documented referral processes for further care and support. Health based places of safety were suitable environments and appropriate processes were in place to keep people safe.

The Trust are awaiting formal written feedback from the CQC which once received will be presented in due course.
Hospital Episode Statistics Data - HES

SLaM submitted records during 2014/15 to the Secondary Users services for inclusion in the Hospital Episode Statistics which are included in the latest published data.

The percentage of records in the published data:

<table>
<thead>
<tr>
<th></th>
<th>In-Patients - SUS data 2014/2015</th>
<th>Out-patients and Community - MHMDS 2014/2015</th>
</tr>
</thead>
<tbody>
<tr>
<td>NHS No</td>
<td>98.5%</td>
<td>99.3%</td>
</tr>
<tr>
<td>GP Practice code</td>
<td>100%</td>
<td>98.4%</td>
</tr>
</tbody>
</table>

Table 1. The percentage of records relating to patient care which included the patient's NHS No and GP practice code.

Information Governance

SLaM's information governance assessment report overall score for 2014/15 was, 90% and was graded green/satisfactory.

The Trust continued to implement improvements around information governance compliance with national standards and key legislation. There have been a number of initiatives to implement the recommendations of the Department of Health Information Governance Review (Caldicott 2). KHP Online, which provides instant sharing of relevant information between care professionals to support direct provision of care within King's Health Partners was implemented in October 2014. Myhealthlocker electronic platform which provides service users online access to relevant information about their treatment, care, condition and medication was commended as a good example of sharing information with service users. Myhealthlocker and KHP Online were cited as best practice examples of successful implementation of the Department of Health IG Review recommendations in the Independent Information Governance Oversight Panel’s Annual Report to the Secretary of State for Health.

Payment by Results Clinical Coding

SLaM was not subject to payment by results clinical coding audit by the Audit Commission during the 2014/2015 financial year.

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

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

- Key data items will continue to be routinely monitored and clinical services are held to account at monthly performance management meetings.
- Data Quality Dashboard has been introduced to give better visibility of key data quality indicators within the organisation.
- The clinical system will be developed to display patient level dashboards to clinicians and administrators encouraging data quality improvement.

Governance Review

The regulators Monitor carried out a review in 2013/2014 which identified service improvements regarding governance arrangements. Following this review the Trust now has a robust governance structure which allows us to understand the Quality of our services and to monitor and support change where needed.

The Quality Sub Committee is a sub-committee of the Trust Board. Its main roles are 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.
2.2.3 National indicators 2014/2015

The Trust is required to report against a list of published indicators which link to existing commitments and national priorities within the periodic review 2014/2015.

They include:

- Care programme Approach (CPA) 7 day follow-up
- Access to Crisis Resolution Home Treatment (HTT)
- Re-admission to hospital within 28 days of discharge
- Service users Experience of Health and Social Care Staff
- Patient safety incidents resulting in severe harm or death

Care programme Approach (CPA) 7 Day follow-up

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

<table>
<thead>
<tr>
<th></th>
<th>SLaM 2011/12</th>
<th>SLaM 2012/13</th>
<th>SLaM 2013/14</th>
<th>SLaM 2014/15</th>
<th>National Average 2014/15</th>
<th>National Target 2014/15</th>
<th>Highest Trust % or Score 2014/15</th>
<th>Lowest Trust % Score 2014/15</th>
</tr>
</thead>
<tbody>
<tr>
<td>CPA - 7 day follow-up</td>
<td>96.3%</td>
<td>96.8%</td>
<td>96.94%</td>
<td><strong>97.4%</strong></td>
<td>97.2%</td>
<td>95%</td>
<td>100%</td>
<td>90%</td>
</tr>
</tbody>
</table>

Table 2: Seven day Follow-up

The lowest/highest scores (for a Trust) are based on the highest and lowest quarterly scores throughout 2014/15 published at [www.england.nhs.uk/statistics](http://www.england.nhs.uk/statistics)
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 numerator 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.

<table>
<thead>
<tr>
<th>Indicator</th>
<th>Target / Threshold</th>
<th>Q1 2014/15</th>
<th>Q2 2014/15</th>
<th>Q3 2014/15</th>
<th>Q4 2014/15</th>
</tr>
</thead>
<tbody>
<tr>
<td>Admissions had access to crisis resolution / home treatment teams</td>
<td>95%</td>
<td>81.9%</td>
<td>95.0%</td>
<td>95.0%</td>
<td>95.6%</td>
</tr>
</tbody>
</table>

Table 4. Quarterly data; Access to crisis resolution

The under-performance in Quarter 1 was the result of not all potential admissions being reviewed by the Home Treatment Teams.

SLaM has taken the following actions to improve this percentage and so the quality of its services, by:

- Home Treatment Team reviewing all potential admissions
- Increased capacity within Home Treatment Team
- Daily review of bed management records to provide assurance of Home Treatment Team consideration or early identification of issues and preventing recurrence.

Note that Psychiatric Liaison Nurse assessments of patients in Emergency Departments are, as in 2013/14, included in the gatekeeping performance figures.
Readmissions to hospital within 28 days of discharge

<table>
<thead>
<tr>
<th>Re-admissions</th>
<th>SLaM 2011/12</th>
<th>SLaM 2012/13</th>
<th>SLaM 2013/14</th>
<th>SLaM 2014/15</th>
</tr>
</thead>
<tbody>
<tr>
<td>Patients readmitted to hospital within 28 days of being discharged</td>
<td>5.1%</td>
<td>5.4%</td>
<td>5.8%</td>
<td>3.95%</td>
</tr>
</tbody>
</table>

Table 5. Readmissions to hospital - adult acute patients only

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

SLaM has implemented the Adult Mental Health Service transformation project in 2 boroughs. The programme aims to reduce admissions and readmissions through additional investment in community teams with a focus on relapse prevention. The other two local boroughs are currently going through the consultation process for this project.

Service Users Experience of Health and Social Care Staff

<table>
<thead>
<tr>
<th>Service users experience of health and Social Care Staff</th>
<th>SLaM 2013/2014</th>
<th>SLaM 2014/2015</th>
<th>Highest Trust % or Score 14/15</th>
<th>Lowest Trust % or Score 14/15</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>8.7</td>
<td>8.1</td>
<td>8.4</td>
<td>7.3</td>
</tr>
</tbody>
</table>

Table 6. 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 2014, overall SLaM scores were slightly higher than the average scores compared to other mental health Trusts. The average Health and Social Care Worker section score for SLaM patients was 8.1 with other Trusts performing in a range of 7.3 to 8.4. This is a decrease from the 2013 SLaM responses which gave an average score for this section of 8.7. However, averages for other Trusts performance also saw a decrease from 2013 where the range was from 8.0 to 9.0.
### Your Health and Social Care Workers

<table>
<thead>
<tr>
<th>Question</th>
<th>Score for this NHS trust</th>
<th>Lowest trust score achieved</th>
<th>Highest trust score achieved</th>
<th>Number of respondents (this trust)</th>
</tr>
</thead>
<tbody>
<tr>
<td>S1 Section score</td>
<td>8.1</td>
<td>7.3</td>
<td>8.4</td>
<td></td>
</tr>
<tr>
<td>Q5 Did the person or people you saw listen carefully to you?</td>
<td>8.5</td>
<td>7.7</td>
<td>8.9</td>
<td>208</td>
</tr>
<tr>
<td>Q6 Were you given enough time to discuss your needs and treatment?</td>
<td>8.0</td>
<td>7.2</td>
<td>8.4</td>
<td>209</td>
</tr>
<tr>
<td>Q7 Did the person or people you saw understand how your mental health needs affect other areas of your life?</td>
<td>7.8</td>
<td>6.5</td>
<td>8.1</td>
<td>203</td>
</tr>
</tbody>
</table>

**Q5** Did the person or people you saw listen carefully to you?

**Q6** Were you given enough time to discuss your needs and treatment?

**Q7** Did the person or people you saw understand how your mental health needs affect other areas of your life?

- **Best performing trusts**
- **About the same**
- **Worst performing trusts**

**‘Better/Worse’** Only displayed when this trust is better/worse than most other trusts

- This trust’s score (NB: Not shown where there are fewer than 30 respondents)

The text to the right of the graph clearly states whether the score for your trust is ‘better’ or ‘worse’ compared with most other trusts in the survey. If there is no text the score is ‘about the same.’

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


### Patient safety incidents resulting in severe harm or death

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

During 2014/2015 there were 6480 incidents reported by the Trust fitting the NRLS criteria for a patient safety incident. Of these 59 are expected to be categorised as ‘severe harm’ and a further 26 as deaths.

The process of reporting Trust data to the NRLS and NRLS publication of national data is retrospective by nature. The latest available benchmarked data is for period Q1-Q2 2014/15. For this period SLaM reported:

<table>
<thead>
<tr>
<th>NRLS Data Q1-Q2 14/15</th>
<th>SLAM 2014/2015</th>
<th>Average for Mental Health Trusts</th>
<th>Highest Trust % or Score 2014/2015</th>
<th>Lowest Trust % or Score 2014/2015</th>
</tr>
</thead>
<tbody>
<tr>
<td>Reported Incidents per 1000 bed days</td>
<td>29.51</td>
<td>33.07</td>
<td>90.04</td>
<td>7.25</td>
</tr>
<tr>
<td>Percentage of incidents resulting in severe harm</td>
<td>0.7%</td>
<td>0.4%</td>
<td>2.9%</td>
<td>0%</td>
</tr>
<tr>
<td>Percentage of incidents reported as deaths</td>
<td>0.4%</td>
<td>0.8%</td>
<td>3.0%</td>
<td>0%</td>
</tr>
</tbody>
</table>

Table 7. NRLS data on reported incidents

SLaM had a slightly lower average rate of incident reporting per 1000 bed days and the percentage of severe harm or death incidents in 2014/15 compared to other MH Trusts. There were no ‘Never Events’ [DH, 2010] reported by the Trust in 2014/15. Never Events are serious, largely preventable patient safety incidents that should not occur if the available preventative measures have been implemented. SLaM considers that this data is described for the following reasons:

As there is not a nationally established and regulated approach to reporting and categorising patient safety incidents, different trusts may choose to apply different approaches and guidance to reporting, categorisation and validation of patient safety incidents. The approach taken to determine the classification of each incident, such as those ‘resulting in severe harm or death’, will often rely on clinical judgement. This judgement may, acceptably, differ between professionals. In addition, the classification of the impact of an incident may be subject to a potentially lengthy investigation which may result in the classification being changed. This change may not be reported externally and the data held by a trust may not be the same as that held by the NRLS. Therefore, it may be difficult to explain the differences between the data reported by the Trusts as this may not be comparable.
SLaM intends to take the following actions to improve this performance, and so the quality and safety of its services:

- Review its reporting and management of serious incidents in light of the new Serious Incident Framework 2015; published in March 2015.
- Continue the implementation of the national patient safety thermometer to encourage staff to report categories of physical health incidents,
- Working closely with the NRLS regarding improved reporting, mapping and the uploading of incidents to ensure real time information.

Monitor Risk Assessment Framework Indicators

SLaM is also required to report quarterly to Monitor (the Foundation Trust regulator) against a list of published indicators which link to existing commitments and national priorities within the periodic review 2014/2015. They are:

<table>
<thead>
<tr>
<th>Indicator</th>
<th>Overall SLaM Performance 2014/15</th>
<th>National Target</th>
</tr>
</thead>
<tbody>
<tr>
<td>Percentage of patients seen with seven days after discharge from hospital</td>
<td>97.4%</td>
<td>95%</td>
</tr>
<tr>
<td>Percentage of patients who had a 12 month care review (patients on the Care Programme Approach - CPA)</td>
<td>97.2%</td>
<td>95%</td>
</tr>
<tr>
<td>Percentage of admissions to the Trust's acute wards that were assessed by the crisis resolution home treatment teams prior to admission</td>
<td>91.5%</td>
<td>95%</td>
</tr>
<tr>
<td>Meeting commitment to serve new psychosis cases by early intervention teams</td>
<td>100%</td>
<td>95%</td>
</tr>
<tr>
<td>Percentage of patients whose transfer of care (from hospital) was delayed</td>
<td>3.1%</td>
<td>&lt;7.5%</td>
</tr>
<tr>
<td>Data Completeness, Mental Health: identifiers - NHS Number, Date of Birth, Post Code, Gender, GP code, Commissioner code</td>
<td>99.38%*</td>
<td>97%</td>
</tr>
<tr>
<td>Data Completeness, Mental Health: outcomes (for patients on CPA) - accommodation and employment status</td>
<td>90%*</td>
<td>50%</td>
</tr>
</tbody>
</table>

Table 8. Monitor Risk Assessment Framework
Part 3: Review of quality performance  
Review of progress made against last year’s priorities

Our 2014/2015 quality priorities were selected after consultations with stakeholders and staff from our services. The following summarises progress made against each priority over the year.

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

Violence and aggression on in-patient wards continues to be a challenge in ensuring that all patients benefit from a safe and therapeutic stay in hospital. For 2014/2015 we stated that this was our top clinical Risk, in line with the new National strategy.

Target We said that in 2014/15 our target was to increase the number of people who when asked say they feel safe in our services. Target >90% of patients feel safe.

Measure We will measure this by asking the questions in our patient surveys; “Do you feel safe?” The question will also be asked as an element of the MH safety thermometer. We will also measure the number of teams who are actively adopting the Care Delivery system.

There were 1801 responses to this question across the inpatient services in 2014/15.

Headline This target was not met.

81% of patients responded positively to the question, “Do you feel safe”. Whilst there was a very slight increase on the preceding years of 1%, it is below the target of 90%. There was an increase in the response rate and the response once again differed by CAG and borough. Factors limiting improvements in this area included the limited roll out of the Care Delivery System in line with our violence reduction strategy.

Pedic Data - ‘Do you feel safe’
Ensuring all service users feel safe in SLaM services is one of the Trust’s equality objectives 2013-16. We have published information on the feelings of safety reported by service users with different protected characteristics as part of our annual equality information. This is available on our website at: 2014 Trust-wide equality information. This priority has been rolled over next year as part of the Trust violence reduction strategy.

**Priority Two – Patient experience: Environment**

We will improve the quality of the environments within our in-patient wards. This priority was identified following and CQC inspectors comments about the environments on some in-patient units in 2013/14.

**Target**

We said that in 2014/15 we would improve the environmental PLACE audit scores by 5% across all in-patient areas.

**Measure**

PLACE audit scores. In 2014/2015 there were 43 place assessments which were undertaken across 11 Trust sites.

**Headline**

This target was met.

The environmental PLACE scores improved over all. These areas were; Cleanliness, Food and hydration, Privacy, Dignity and Wellbeing and Condition Appearance and Maintenance.

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

<table>
<thead>
<tr>
<th>PLACE</th>
<th>Cleanliness</th>
<th>Food and Hydration</th>
<th>Privacy, Dignity and Wellbeing</th>
<th>Condition, Appearance and Maintenance</th>
</tr>
</thead>
<tbody>
<tr>
<td>2013</td>
<td>82%</td>
<td>78%</td>
<td>91%</td>
<td>81%</td>
</tr>
<tr>
<td>2014</td>
<td>92%</td>
<td>92%</td>
<td>94%</td>
<td>96%</td>
</tr>
<tr>
<td>% Improvements</td>
<td>10%</td>
<td>14%</td>
<td>3%</td>
<td>15%</td>
</tr>
</tbody>
</table>

Service improvements over 2014/2015 included the refurbishment of ward areas following both the anti-ligature reduction programme and the ASCOM (Alarm installation).

There were Individual ward refurbishment programmes as well the Ladywell Unit refresh programme.

In 2014/2015 the Hotel Services Team introduced the ‘Spot Light Reports’ which monitored the cleanliness and meal standards provided on In Patient Units and make the necessary improvements. This work will continue in 2015/2016.
Priority Three - Patient experience; individual service

We will ensure that all patients receive individual service at medication and mealtimes when in hospital. This priority was identified through patient feedback and the SLaM privacy and dignity strategy work.

Target
No patient will queue for medication or meals when in hospital.

Measure
We will measure this by observation audits of practice on in-patient units.

Headline
This target was not met.

An audit carried out of 53 inpatient wards showed that 24% of patients queued up for medication whilst 32% of patients queued up for mealtimes. Feedback from Ward Managers stated the target of 100% was difficult to achieve. This was due in part despite efforts by staff, some patients choosing to queue. The recommendations highlight the work that will continue by clinical areas to improve in this area and this will be re-audited next year.

 Queue for Medication

<table>
<thead>
<tr>
<th></th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>24%</td>
<td>76%</td>
</tr>
</tbody>
</table>

 Queue for Mealtimes

<table>
<thead>
<tr>
<th></th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>32%</td>
<td>68%</td>
</tr>
</tbody>
</table>

Nevertheless, it is important the Trust continues to monitor this priority during the following year to ensure patients receive an individual service at medication and mealtimes when in hospital.

Where queuing for meals and medication took place, the following was identified by ward managers as measures put in place to help reduce queuing during these times;

1. Issues regarding queuing have been raised with patients (community meetings).
2. Posters have been put up and service users have been advised that queuing is not necessary.
3. Service users have been allocated numbers to come forward in order to avoid queuing.
4. The problem of queuing has been discussed in both staff meetings and patient community groups.
5. Each table is called at a time to avoid queues.
6. Service users are constantly encouraged to order their meals to avoid queuing.
7. Service users are encouraged to sit at their tables and wait their turn.
8. Service users are called one by one for medication.
Priority Four - Clinical Effectiveness; Physical healthcare

This target recognises the importance in improving our screening of patients for cardiovascular and metabolic disease. This is a NICE guideline requirement, and a continuation of the CQUIN work during 2013/14. This target will now include patients with bi-polar mood disorders as well as schizoaffective disorders.

**Target**

90% of eligible patient (patients with psychosis, bi-polar illnesses and all in-patients) six key cardio metabolic test results recorded for:

- Smoking status
- Lifestyle (including exercise and diet)
- Body Mass Index
- Blood pressure
- Blood Glucose
- Blood lipids.

**Measure**

This was measured through a process similar to the 13/14 National Audit of Schizophrenia, on cardio metabolic risk factors in patients with schizophrenia.

A mini audit in June gave the Trust a baseline to work from.

**Headline**

This target was not met.

The results from the national audit shows the Trust achieved 83%.

<table>
<thead>
<tr>
<th>Organisation name</th>
<th>Number of forms received</th>
<th>% refusal to undergo screening</th>
<th>Analysis 1 Final % score</th>
</tr>
</thead>
<tbody>
<tr>
<td>South London and Maudsley NHS Foundation Trust</td>
<td>100</td>
<td>4.71</td>
<td>83.00</td>
</tr>
</tbody>
</table>

Whilst this target was not met the Trust has made significant improvement from baseline figures earlier in the year. This will continue to be a priority for next year where the Trust will build on work carried out in 14/15. As outlined earlier the Trust has gained resources to implement an electronic observation system (E-OBS) which will enable clinical staff to record and monitor physical observations both efficiently and effectively. This will involve a system of escalation for action.
**Priority Five - Clinical Effectiveness: No smoking**

We will help patients to quit smoking and move to no smoking across all Trust sites and in all clinical environments by November 2014.

**Target**

We will record the smoking status of 85% of all patients seen. 50% of smokers will be offered nicotine replacement therapy or counselling.

**Measure**

Number of patients whose smoking status is recorded. Number offered intervention. Take up of NRT, and psychological interventions.

**Headline**

**This target was met.**

Smoking status was recorded in 94/106 (89%) of the cases. This is an increase from Quarter 1 14/15 audit (63/106, 59%) Target met: 20/33 (61%) smokers offered any type of intervention (brief intervention, NRT, referred to smoking cessation service). This is an improvement from the audit of Quarter 1, 14/15 - 9/16, (56%)

The Trust went smoke free on October 1st 2014. At the end of Quarter one 14/15, compliance with the number of service users with smoking status recorded was 59% and 56% of smokers with a Physical Health Screen were documented to have been offered any type of smoking intervention. (Brief intervention, NRT, referred to smoking intervention). After quality improvement work throughout the year a further trust audit was carried out in Quarter 4, 2014/2015.

30/33 (91%) of smokers were given advice to stop smoking
5/7 (71%) of smokers referred to smoking cessation services had a smoking cessation care plan.

**Training in tobacco dependence treatment**

The Addictions Department within SLAM provides two levels of training; Basic education - a level 1 mental health and tobacco dependence treatment E Learning Course (1-2 hours). All staff who have clinical contact are expected to complete this.

Up until December 2014, 1311 staff had completed level 1 training, 360 from the Psychosis CAG, which is approx. 30% of eligible Psychosis staff.

**Staff completed Level 1**
Priority Six - Clinical Effectiveness - Improve GP access to SLaM assessments

We will improve GP access to SLaM assessments, so that more patients are seen quicker for first assessment at home and in the GP surgery. The priority has been identified through patient feedback, and is a part of our Easy In, Easy Out Strategy, in Lambeth and Lewisham.

**Target**
Our target was to see 20% more patients for first assessment in GP surgeries and at home than in 2013/14.

**Measure**
We said we would measure this by extracting data on patient assessments from our health records system.

**Headline**
This target was not met.

Whilst the audit showed there had been a decrease of 12% regarding assessments being carried out at the Team base it did not reach the increased 20% target of assessments being carried out at home or GP surgery. There will be a re-audit of this next year following quality improvement work from recommendations below.

**Recommendations made as a result of the audit and currently being followed up by the CAG Management Team is as follows:**

- A minimum of 20% of patients will be seen for 1st assessments at the patient's home or GP surgery.
- Team Leaders/Managers to raise this as a priority at meetings and team briefings.
- This could be added as one of the performance management goals for both, team leaders and staff.
Priority Seven - Patient safety: stop the transfer of acute patients to private sector hospital beds

There have been clinical risks associated with the transfer of acute patients to private sector hospital beds. Feedback from patients also indicated that most patients prefer to stay in SLaM wards. In 2014/2015 we aimed to stop the transfer of acute patients to private sector hospital beds.

**Target**

We said that by the end of June no more than six PICU (Psychiatric Intensive Care Units) patients will be in overspill placements and that no more than two general AMH (acute) patients will be in overspill placements. This position will be held throughout 2014.

**Measure**

We would measure the number of patients transferred to acute overspill beds outside the Trust.

**Headline**

This target was met regarding PICU beds. This target was not met regarding AMH beds.

The average number of patients in PICU overspill beds between July – March 2014/15 was 6. However the target was not met for the number of patients in acute overspill beds for AMH patients where this averaged 5.

### Staff Completed Level 1

<table>
<thead>
<tr>
<th></th>
<th>April - June 2014</th>
<th>July - March 2014 / 2015</th>
</tr>
</thead>
<tbody>
<tr>
<td>Acute</td>
<td>16</td>
<td>14</td>
</tr>
<tr>
<td>PICU</td>
<td>12</td>
<td>8</td>
</tr>
<tr>
<td></td>
<td>10</td>
<td>6</td>
</tr>
<tr>
<td></td>
<td>8</td>
<td>4</td>
</tr>
<tr>
<td></td>
<td>6</td>
<td>2</td>
</tr>
<tr>
<td></td>
<td>4</td>
<td>0</td>
</tr>
<tr>
<td></td>
<td>2</td>
<td></td>
</tr>
<tr>
<td></td>
<td>0</td>
<td></td>
</tr>
</tbody>
</table>

Overall the Trust has seen a reduction in the use of overspill beds and had met the target set in both areas in the months September to November. However the latter part of the financial year has shown the number of overspill beds slowing increasing which has affected the overall average monthly and yearly figures. The recent increase has been due to:

- The Trust refurbishment programme carried out on a number of acute wards resulting in the reduction of approximately 10-12 beds resulting in the use of overspill acute beds for AMH patients.
- A national trend for the demand on acute beds.

In order to mitigate that the Trust works within its own bed capacity, there are robust bed management processes in place, with daily (twice per day in extremis) demand and capacity meetings held across the Trust and an overspill review team to ensure quality and safety of care and patient experience.
Priority Eight - Patient safety: Accessing help in a crisis

No one should experience being turned away when in a crisis. This priority was identified as a theme from patient feedback. In 2014/2015 we said we would make it easier for patients to access help in a crisis.

Target

Target is that at least 70% of all community patients asked will respond positively to this survey question ‘Have you been able to access help when in a crisis?’.

Measure

We will measure this by asking patients about their experience, in the form of surveys.

Headline

This target was met.

Community patients were asked two questions covering different periods over the year in local trust surveys (outlined further below in graphs six and seven). They were asked their viewpoint on accessing services and the information regarding crisis services. The proportion of community patients who responded positively to the question of accessing services was 81%. The composite result of the two surveys was 77.14%.

There were 3180 responses to this question in 2014/15.

NB: The data on accessing mental health services covers April to October 2014 and the data on knowing what to do in a mental health crisis covers April 2014 to March 2015. The composite result of the two surveys was 77.14%. The change came about as a result of the Trust revising its patient surveys during 2014/15 in response to the following two issues:

- the requirement to ask the Friends and Family Test question, and
- feedback from service users and staff that surveys were too long.

The five new core questions in community surveys includes ‘Do you know what to do in an emergency mental health situation’ as this is important to service users and carers and is something the Trust must continue to improve on. The question on accessing mental health services is no longer part of community surveys.

Can you access mental health services quickly and easily if you need to?

![Graph showing positive and negative responses](image-url)
The pedic survey showed positive results, alongside the initial feedback following the thematic review by the CQC (outlined earlier in this report), which assessed people’s experience of mental health crisis care provided within the local authority area (Lambeth). However, we know from service users, carers and other stakeholders during the consultation process for next year’s key priorities that this is still an important issue and for this reason it is one of the priorities for next year.

**Do you know what to do in an emergency mental health crisis?**

![Pie chart showing responses](image)

- **Positive Response:** 73%
- **Negative Response:** 27%

Good information and patients knowing what to do in a crisis is important in the implementation of good crisis care. There will be the development of new publicity materials with the implementation of the new crisis line in 15/16 and this will be a key priority for next year.

Linked to our provision of crisis of services, at times where place of safety suites are unavailable this can relate to when there is damage is caused to a place of safety suite themselves. Therefore unavailable whilst being repaired or there are periods the suites are unavailable because of high levels of demand on the staff of the wards where the place of safety suites are based. The Trust is currently reviewing its place of safety pathway in order to reduce the length of stay and ensure rapid decision making which will hopefully improve the patient’s pathway onto onward care.
Priority Nine - Patient experience; Care planning

In 2014/2015 we aimed to improve the way we involved patients and their carers in their care planning and make sure patients understand their care plans. This priority was based on both Patient survey findings and a CQUIN target, (commissioning for quality and innovation).

**Target**
At least 80% of all adult patients will have been encouraged to co-produce their care plans with staff.

**Measure**
We measured this by extracting data from our health records system. We will also conduct an audit of the quality of these care plans.

**Headline**
This target was met.
Trust audit of extracting data from health records showed that 87.1% of patients from Adult services had a Recovery and Support Plan.

The CQUIN target was in line with recent policy initiatives such as ‘No Health without Mental Health’ which stated an underlying value of ensuring that users identify and achieve outcomes that matter to them, and that users are at the centre of their own care.

The evidence of a support and recovery approach being at the centre of the support planning process is well-defined goals that address the user's personal aims and aspirations. The inclusion of self-defined recovery goals was a first step towards assessing the delivery of a recovery approach: this has been an indicator in previous two contracts.

<table>
<thead>
<tr>
<th>Patients with a Recovery and Support Plan</th>
<th>Patients on CPA</th>
<th>With Recovery Support Plan</th>
<th>% with RSP</th>
</tr>
</thead>
<tbody>
<tr>
<td>Trust Total</td>
<td>4001</td>
<td>3485</td>
<td>87.1%</td>
</tr>
</tbody>
</table>

An audit of the quality of completed Recovery and Support Care plans was also required as part of the CQUIN requirement. The audit highlighted significant improvement in results from the audit carried out in Q1 14/15 concerning the quality of the care plans and those being completed in the first person.

Where the Recovery and Support plan had only been partially filled in or had not been written in the first person, there was evidence documented of difficulty in engaging the service user in this process which was sometimes due to capacity issues but also patient choice. Recommendations from the audit included further training for staff in this area.
National patient survey of people who use community mental health services: SLaM report 2014

The national patient survey was returned by 219 SLaM patients giving a response rate of 27% which is just below the national average for all mental health trusts of 29%

Overall, SLaM’s results fell in the amber section in 7 out of the 8 sections of the survey meaning, our results were ‘about the same’ as most other trusts. In the remaining ‘Crisis Care’ section our overall score was unavailable. In the final ‘Overall’ Section, SLaM performed ‘about the same as other trusts. In the graphics below the Trust score is represented by a small diamond. If the score is placed in the amber section of the Red, Amber, Green (RAG) rating then that result is considered ‘about the same’ as most other trusts. If the score is in the red section of the RAG, the result is considered ‘worse’ than most other trusts and likewise if the score is in the green section, the result is considered ‘better’ than most other trusts.

Out of the 32 individual questions in the survey, the top ranking scores for SLaM compared to other mental health trusts in England was found for the following question:

**Section 1: Your Health and Social Care Workers**

Q7 Did the person or people you saw understand how your mental health needs affect other areas of your life?

**Section 4: Reviewing Your Care**

For no questions in the 2014 Survey of people who use community mental health services did SLaM perform among the worst performing trusts. Where SLaM was on the border of the ‘worst’ and ‘among the same’ for whom to contact out of office hours in a crisis in 2013, the 2014 results saw an improvement:

Q17 Did you feel that decisions were made together by you and the person you saw during this discussion?

**Section 6: Crisis Care**

Q21 Do you know who to contact out of office hours if you have a crisis?
Improvement Plans

SLaM are looking to improve on a range of patient experience areas throughout 2015/16 all of which are closely related to the National Community Survey but are also inclusive of other areas that are equally important to service users, carers and staff.

The questions below are patient experience priorities for all of services and although we have seen recent improvements, we are aiming to further progress the issues below by working more collaboratively with service users and carers and by offering easier access to respond to the questions.

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

The Trust recognises that for patients and carers the knowledge of who to contact at times of crisis is very important. Therefore the Trust has made this a priority for next year. With the implementation of the new crisis line this year this will hopefully improve the patient and carer experience in this area.
National Staff Survey 2014 – Results

This year 1805 employees of Trust’s eligible workforce completed the survey. This was a larger sample than last year. The response rate to the survey was 42% which is an improvement on the 2013 response rate of 37%.

Number of Staff recommending the Trust

In the 2014 staff survey, SLaM performed slightly worse than the year before on the question ‘would staff recommend the trust as a place to work or receive treatment?’ However, SLaM still performed slightly above the national average on this question. The SLaM Trust score for this question was 3.61 compared to the national median score of 3.57 for other mental health trusts. - see below.

KEY FINDING 24: Staff recommendation of the trust as a place to work or receive treatment
(the higher the score the better)

<table>
<thead>
<tr>
<th></th>
<th>Scale summary score</th>
</tr>
</thead>
<tbody>
<tr>
<td>Trust score 2014</td>
<td>3.61</td>
</tr>
<tr>
<td>Trust score 2013</td>
<td>3.67</td>
</tr>
<tr>
<td>National 2014 average for mental health/learning disability trusts</td>
<td>3.57</td>
</tr>
<tr>
<td>Best 2014 score for mental health/learning disability trusts</td>
<td>4.15</td>
</tr>
</tbody>
</table>
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 agreeing that they would feel secure raising concerns about unsafe clinical practice.**
Trust Score: 73%          National Average: 69%

**Percentage of staff able to contribute towards improvements at work.**
Trust Score: 75%          National Average: 72%

**Percentage of staff agreeing that feedback from patients/service users is used to make informed decisions in their directorate/department.**
Trust Score: 62%          National Average: 53%

**Percentage of staff feeling satisfied with the quality of work and patient care they are able to deliver.**
Trust Score: 80%          National Average: 76%

**Percentage of staff agreeing that their role makes a difference to patients.**
Trust Score: 91%         National Average: 89%

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

**Percentage of staff believing the Trust provides equal opportunities for career progression or promotion.**
Trust Score: 77%        National Average: 86%

**Percentage of staff experiencing harassment, bullying or abuse from patients, relatives or the public in the last 12 months.**
Trust Score: 36%        National Average: 29%

**Percentage of staff experiencing physical violence from staff in the last 12 months.**
Trust Score: 6%          National Average: 3%

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

**Percentage of staff experiencing physical violence from patients, relatives or the public in the last 12 months.**
Trust Score: 24%         National Average: 18%
The following is the area where the experience of staff has improved on the previous annual survey:

**Percentage of staff having equality and diversity training in the last 12 months.**

Trust Score 2014: 58%          Trust Score 2013: 45%

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

**Percentage of staff believing the Trust provides equal opportunities for career progression or promotion.**

Trust Score 2014: 77%         Trust Score 2013: 83%

In addition, our Trust score for overall staff engagement has gone up at 3.76 (3.74 in 2013) compared to a score of 3.72 which was the national average for all mental health/learning disability Trusts.

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**Overall Staff Engagement**

![Scale summary score chart](chart)

From the 29 categories within the survey covering the four pledges, staff satisfaction, equality and diversity and patient satisfaction, statistically significant changes from the year before were reported:

- 25 categories remain unchanged from the previous year
- 1 categories were more positive than previous year
- 1 categories were less positive than previous year
- 2 no comparison from year before
Areas for Action and Next Steps

At a Trust-wide level, there are themes that have been identified in the lowest five ranking areas that are of concern to us and work is required to identify what can be done to address these. The themes of equality and discrimination, harassment and bullying and violence are of concern and will be brought formally to the Trust Quality Sub Committee and in turn to the prevention and management of violence and aggression for their recommendations and oversight.

The work being done following the Francis Report also encourages trusts to identify staff champions and to build reflection into practice, which in turn has an impact on staff and consequently service user experience. In the report on the Francis recommendations, it is reinforced that a Trust-wide plan to address the concerns highlighted in the Staff Survey is required. In this report, it confirms that bullying and harassment are worse for BME groups but a zero tolerance policy for bullying will require a wider understanding of the issues involved. SLaM staff and particularly BME staff do not perceive that equal opportunities for career progression and work has already commenced to address this.

The report also reminds us that SLaM is also in the worst 20% in terms of the percentage of staff who experience physical violence (from patients/relatives/public and from other staff) and those who experience discrimination. Both are also worse for BME staff.

At a local level, each CAG and Directorate has been asked to develop an Action Plan in relation to the responses in the staff survey. This should be based on the requirements identified within the report for their specific areas as some CAGs may need to develop and improve approaches to particular themes. There will need to be regular updates on progress through the CAG HR Business Partners. It is important that local issues are identified and staff are given the opportunity to work on their resolution and for the CAGs to reassure their staff that they have heard the feedback and are addressing it.

Staff Training

This year has seen a focus on improving attendance with mandatory training especially in the latter part of the year. This has involved moving to a single system of recording of mandatory training which will improve reliability of data in the future. There has been an overall increase in mandatory training compliance during the latter part of the year and this will continue. The core subjects for mandatory training have been reviewed so that it is targeted to the specific groups of staff that require the training and all training is being reviewed to ensure that all mandatory training is absolutely appropriate.

Workforce: safer staffing

1. A Safer Staffing review paper goes to the Board every 6 months. This considers the current position and describes planned actions.

2. Safer Staffing breaches are reported to the Quality Sub Committee and the Board on a monthly basis, as a part of the Quality dashboard. There have been discussions regarding issues arising at both.

3. Bank and agency usage has been discussed at both the Board and Quality Sub Committee as have actions outlined to reduce agency usage. The main issue is the need to have more effective and on-going recruitment processes for Band 5 inpatient nurses and Band 6 community care co-coordinators. A committee chaired by the Director of Nursing now meets regularly to address this issue. A paper describing our new processes is going to the QSC in June 2015.
SLaM Equality Objectives 2013-16

During 2014-15 the trust has continued to deliver its equality objectives:

1. All SLaM service users have a say in their care
2. SLaM staff treat all service users and carers well and help them achieve the goals they set for their recovery
3. All service users feel safe in SLaM services
4. Roll out and embed the Trust’s five Commitments for all staff
5. Show leadership on equality through our communication and behaviour

We published an update on our equality objective delivery in January 2015. This is available on our website at: A report on our progress on equality in 2014.

Much of the work to achieve these objectives supports the delivery of our quality priorities and we will continue to co-ordinate our equality and quality delivery work during 2015-16. To support this work we have undertaken an equality impact assessment to inform the development of the Trust’s new Quality Strategy. This brings together evidence that the Trust will use to inform the planning and delivery of future quality improvement work and provides a baseline to monitor the anticipated positive impacts the strategy aims to deliver for service users with all protected characteristics.
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

April 2015

The Clinical Commissioning Groups contracting with the South London and Maudsley NHS Foundation Trust have reviewed the Trust's Quality Account for 2014/15. We thank the Trust for the opportunity to comment on the 2014/15 Quality Account and for seeking the views of the CCGs in its development.

We have worked closely with the Trust during the year to seek assurance of the quality of the services it provides and have appreciated the open and frank discussions that we have been able to have at the 4 Borough Clinical Quality Review Group and at other meetings. The Trust has responded to our challenges quickly and clearly when we have sought further clarification or have expressed concerns.

The CCGs were pleased to be invited to a meeting to develop the Trust’s quality priorities for 2015/16 and we endorse the priorities as set out in the Quality Account. We are pleased to see specific plans relating to carers, working towards patient-directed outcomes, risk assessments and substance misuse. We would also like to recognise the achievements SLAM have made in becoming smoke free.

We are encouraged to see a focus on the Recovery Model with training being provided to a majority service user audience through the ‘Recovery College’ and a new focus on service users feeling that they are fully involved in their own care through a co-constructed care plan. We commend the trust on setting plans to improve the quality of the Inpatient environment in 2015/16. The CCGs are pleased to see learning from Serious Incidents and complaints has been used to drive not just specific improvements but also has been used strategically to inform new policies and guidance.

During the past year we have monitored the further development and implementation of the Trust’s Quality Strategy and have been working with the Trust to agree and develop a robust Quality Information Schedule that will provide regular, routine and rigorous quality indicator data for quality performance monitoring.

As part of our quality assurance work the CCGs and the Trust, working together, completed a detailed scrutiny of the effectiveness of the Trust’s Suicide Prevention Strategy. We were pleased to see the Trust implement its no smoking policy and the support that was provided to patients and staff. We reviewed the work that the Trust undertaken to agree and establish appropriate staffing levels across its wards and received assurance that the Trust had many and wide ranging processes to hear and respond to feedback and complaints from patients.

We note the trust did not achieve their aim to carry out more assessments near to the patient and recommend that the Trust seeks creative and innovative solutions. We agree with the Trust that more needs to be done to help patients and staff feel safe from violence and aggression on the wards. This has been a long-standing issue for the Trust for which there is no easy solution but we are committed to working together to monitor and support the implementation of the violence reduction strategy so that patients and staff feel safe and supported in all care settings.

The CCGs are aware that there is very little evidence the Trust can use to establish “safer staffing” levels across its services but will continue to work with the Trust to agree appropriate skill mix and staff numbers to ensure that its services are able to provide healthcare that is safe, effective and responsive to patient’s needs.
In addition to the agreed priority areas listed in the Quality Account we will continue to work together to assure the quality of services across the quality domains of patient safety, clinical effectiveness and patient experience. We will seek assurance that the Trust has appropriate procedures to implement the new guidance on the Deprivation of Liberty Standards and the new NHS England Serious Incident Framework.

We look forward to seeing the Trust making progress against all its quality priorities during 2015/2016.
Council of Governors reply to the Quality Accounts 2014/2015
May 2015

The governors welcome the publication of this year’s Quality Account and acknowledge that its targets have been demanding for the 2014/15 period. Therefore, it becomes even more important to be able to follow the narrative of the improvement work that follows the effort involved in working towards each of these targets. It has been noticed that such analysis was provided for 2014/15 Priorities Three and Five.

We strongly recommend future reports to include more detailed reporting of the findings of internal audits in line with the analyses and recommendations of the Francis Report. Similarly, it is still not easy to determine the overall response rates to the survey results. As in previous years, the governors strongly recommend that numeric values are triangulated with feedback obtained from service user and carer groups (qualitative data).

The governors appreciated the opportunity to actively input into the shaping of the Trust’s 5-year Quality Strategy which underlies the concrete 2015/16 quality priorities. We would also welcome a more direct input into the annual priorities. Trust service user and carer involvement has been one of its strengths and its forum, EPIC, is in the process of adopting the NSUN 4PI standards (National Survivor User Network). A member of the governors’ Quality Group now observes the Trust Board Quality Sub-Committee that allows further insights and inputs into the quality governance process.

The governors welcome the decision to maintain the in-patient safety target in 2015/16 Quality Priority 1, i.e. 90% of patients feeling safe in our inpatient facilities. In particular, the large scale implementation of the Care Delivery Systems appears to be a major step towards achieving this goal. The choice of Quality Priority 2 reflects the governors’ expressed interest in crisis care. The Trust should also consider measuring the level of satisfaction of service users and carers with the available crisis care.

The governors positively noticed that the 2015/16 quality priorities are much more balanced towards community care. Priority Five focuses exclusively on carers’ assessments and a more specific and aspirational target could increase carer satisfaction.
Healthwatch Southwark, Lambeth and Bromley & Lewisham’s response to SLaM NHS Foundation Trust’s Quality Accounts for 2014/15

This is a joint response to the South London & Maudsley Foundation Trust (SLaM) Quality Account 2014-2015 from Local Healthwatch Southwark, Lambeth and Bromley & Lewisham because we share services which operate across these boroughs. We appreciate the opportunity to comment on the quality of the services provided by SLaM across their community and inpatient services.

General comments

We appreciate the progressive work SLaM is undertaking, across its wide geographical patch and services. However, the report highlights the lack of continuity across the different services and boroughs. There is little clarity on services that operate in one or two boroughs, in certain CAGs or across the four boroughs. A helpful distinction and overview of this would be helpful to contextualise future quality accounts.

We felt there was little harmony, integration or linkages across the priorities where they could be made. We feel collectively it could increase impact. For example, crisis services across the board, or risk assessments could have more triage.

Some of the priorities/measures lacked a listening/patient engagement focus. More work needs to be done to check with patients that the measure/questions asked were the right ones i.e. perhaps through a checklist that people refer to. The operational and clinical perspectives could be because of the high use of audit/data extraction in the priorities/Measures and we queried if some priorities may benefit from more dedicated work/Projects. In addition, there needs to be more involvement of patient and user input into the design of solutions. It would be very useful to include user input, listen and understand their perspectives because ultimately these priorities are intended to improve the quality of care for patients.

We would like to see references to the training that we are aware are available e.g. Recovery College, peer support within SLaM, or the leaflet on self-care for physical and wellbeing for users and carers. It would be useful to understand how the Trust communicates (Communication strategy) and audits its frontline staff to make sure they are aware of key services/documents that are of value to service users and their families, particularly when out in the community.

Finally, the duty of candour should be published to all patients and staff, e.g. in the ‘what you can expect from services’ booklet.

Note: it can be difficult to comment on the Trust’s performance with missing information, particularly on important trust indicators such as the Care Programme Approach or the Readmissions rate for example.
Last year’s priorities for 2014-2015

Some priority targets are not met but are not carried over. We would like to see that this is not forgotten and work is still being done to improve upon what you could not meet.

No. of patients feeling safe: It will be useful to see the difference in performance between CAGs and the boroughs and why this is, to improve learning and support. The format/question could be articulated better to capture the experience/feelings, but also separates out responses in terms of ‘being in the ward’ and the ‘actual experience’, which are two different aspects. For example ‘do you feel that the ward is safe?’ - it will be useful to know when this is asked, i.e. post treatment/after discharge, as this could affect the type of response. It was not clear how many patients were asked, so the proportion is not clear. Furthermore, differentiating services and exploring what makes it ‘unsafe’, can inform how the trust can respond to this data.

Accessing help in a Crisis:
We fully support this focus; however we feel that the priority improvement is limited in terms of quality support.

We receive a lot of feedback and it is widely emphasised that A&E is not the best place for someone suffering from a mental health crisis. While our user feedback on the treatment received at A&E is variable, upon hindsight, patients themselves question ‘if being in A&E is a good thing.’ Therefore we are concerned at the slow progress in King’s A&E Mental Health suite and a gap in service development.

There is no mention of care or crisis plans in relation to accessing help in a crisis. We would like to know what role these documents have in planning in advance - in relation to how and where to access support in a crisis situation.

We suggest getting external feedback i.e. police and A&E staff, who have contact with them.

You have met your target of at least 70% of community patients responding positively to accessing information and crisis services, however we feel this target should be increased because we are concerned about the 30% who do not know what to do?

Across the trust, there should be more clarity on patients given explicit instructions on discharge and not just a leaflet with advice.

Overspill placements:
We would like to see information/focus on the individuals experience who may be in an overspill placement and its effects on ‘roommates’, as this seems to be viewed operationally.

We would like to see information on the bed capacity and spread across the four boroughs and if this has an effect on each borough’s bed capacity. It will be useful to know if demand is from national capacity or from within SLaM the four boroughs that SLaM provides care for.

We welcome the refurbishment programmes. We would encourage a review of bed capacity after this is in place.

Screening of cardiovascular & metabolic diseases:
Patients on anti-psychotic drugs can be known to have (under) weight issues, which can distort the usefulness of the indicator measurement. We would like to know what is also being done to address the causes, alongside the reported measure. What steps are being taken to improve physical alongside their mental health? For example, user feedback has highlighted the variable knowledge and input of ward staff in relation to physical health. Recording indicator results is great; however tailored consideration in relation to the effects of drugs/medication on these indicators should be carefully interpreted. I.e. side effects.
We questioned why only specific patients were eligible to be assessed on these indicators and suggest widening this out to include all patients. We would like to see these indicators be explored in a more holistic range incorporating lifestyle.

**No smoking policy:**
We appreciate the smoking policy, its offer of support and its positive intentions to those with mental health difficulties.

We would like to see more qualitative context around the indicators, particularly around additional support for vulnerable people. Healthwatch Southwark’s recent enter and view report into an inpatient ward, highlighted issues around tailored support and risk assessment for those who may find it challenging to comply with. It will be useful to seek feedback from patients on the wards about how they are finding this change, and also outcomes particularly around vulnerable individuals who need additional support. Alongside this information on those that relapse and support outside of interventions.

**Improve GP access to SLaM assessments:**
We feel patient choice should be an important consideration in this priority, e.g. if they prefer to have assessment at GP or the current locations provided by SLaM. SLaM should be mindful of this when focusing activity to increase access to SLaM assessments in different settings, which we believe to be a positive step to widen access. Alongside this, better communication is needed between GP and SLaM around assessments to include more support to GPs to feel equipped.

It will be helpful to consider how this could be expanded to include other community sites such as the mental wellbeing hub in Southwark and other community-based development such as the future local care networks.

**Feeling Involved:**
We feel the term involved is quite vague and do not fully understand what this term implies. The measures did not show the extent of involvement.

**Individual service at medication/meal times:**
Good solutions on how to manage it, but it will need monitoring.

**Quality of ward environment:**
We suggest consultation with users on the environment they want would improve their experience there. We suggest that review of outdoor space and activities be considered within this priority.

**Co-producing plans with staff:**
There seemed to be no care measurement. There does not appear to include any user engagement on this. We believe doing so will give insightful perspectives to inform your quality audits.
This year’s priorities for 2015-2016

We hope our comments and suggestions below are used to help shape this year’s priorities, particularly those carried forward from last year.

No. of patients feeling safe:
In addition to the violence reduction strategy, it could be helpful to explore ways to empower patients to report abuse, which could be through independent discussions with patients or routine independent surveys.

Access Crisis:
We are concerned there is no consistency or continuity of service across all four boroughs. We would like to see a programme design for the whole year and clarify around the types of services provided in each borough in accessing crisis services.

We are concerned at the still in-development stage of King’s A&E Mental Health services and that it is progressing too slowly to improve facilities. Currently, Kings A&E sees many present in crisis. Kings are a busy A&E and a hub of activity is not the right place to care for people in crisis. They also do not have the adequate facilities and spacing for those in crisis to be cared for. There should be a separate area for on-site liaison/crisis service away from A&E activity passing through.

We recommend exploring external feedback i.e. A&E and Police services, in order to get a fuller insight and experience by those affected.

We feel the crisis line is a good start however most in crisis are unable to articulate themselves, especially on the phone. Crisis solution should be far larger than just a telephone line and should be a multi-disciplinary solution. We hope this is a first step and part of a wider development / programme/vision on crisis services. Key aspects to be included should be a more calming and welcoming place, consistent communication, referrals and information across multi-partners who have a stake or are affected.

We discussed re-phrasing the question with ‘are you happy with your experience in a mental health crisis’ or ‘have you been able to access (helpful) support in a crisis?’. It would be useful to explore what mental health crisis means to patients, we realise it is subjective, however we also realise that some could perceive this as immediate/very-soon intervention or easier access to GP/CMHT. Understanding could help develop your crisis support. Exploring crisis teams accepting self-referrals, at least for a subgroup of people e.g. those known to the team and discharged to their GP.

As mentioned earlier, this target is set low at 70%; we would like to see this target significantly increased, perhaps to 90%.

Feeling Involved:
In light of our above comments on this priority, internal work is needed on re-phrasing the questions on a more basic level. i.e. Do you have a care plan? Do you agree with it/does your care plan reflect your desires or needs? Do you have a copy of your care plan? Etc.

It should not just be about co-producing a plan, but when - finding the right time to have a dialogue to listen and to engage on this. We questioned if, to patients, it really mattered who writes the care plan but as long as it is right. Further work to explore this aspect would make this more meaningful.

In terms of joining up some of the services, across priorities, we suggest if an advocate or something else, could check discharge plan, care plan, and then reviewed at the 7-day discharge contact, to avoid separate service and instead tag onto an existing service.
**Improve risk assessments:**
We agree with this priority, our feedback highlights variable experiences of risk assessment depending on what service was used i.e. CMDT, Ward, and Crisis. We want to emphasis it is a much broader issue on how risk is managed. In some areas, they are risk-averse, whilst others are risk-tolerant. There needs to be more systematic reasoning including a balanced view from health professional.

**Home treatment team (HTT):**
Positive feedback about the service, however the measure needs to be contextualised to understand reason behind the figures i.e. the whys - if person deteriorated through no fault of the HTT.

Alcohol and non-prescribed drugs: this needs to be handled sensitively to avoid assuming everyone uses one or the other or both. Where this conversation takes place or initiated is also just as important and to consider its appropriateness, and effect on individuals.

**Carer’s:**
This is a positive development. Should consider carer’s involvement with patients care plans or how carers can be involved.

**Audits/Clinical:**
We support the view that lessons learnt from complaints and serious incidences will be considered for future policies, however we would like assurance that actions are also considered when sent to topic lead.

It would be helpful to see the utilisation and experience of both (staff) and My health locker (for users) which focuses on access to information.

**National Indicators**

**Psychological Therapies:**
We are concerned that SLaM are continuing to not meet its targets to offer CBT to its users and also the failure to offer family intervention, especially in comparison to national figures. We would like to see specific targets for improvement.

**Mental Health:**
Outcomes (for patients on CPA) – accommodation and employment status - 50% It is crucial that there is evidence of ‘outcomes’ for service users, particularly in reference to the above. We would like to see specific actions on how this is going to be addressed and improved.

**National staff survey:**
We were very concerned and surprised to see that SLaM was in the top 20% on staff experiencing physical violence. We support the action that each CAG will develop action plan to address this. We would like to see how or if the staff survey results around BME equality issues are being addressed SLaM’s equality objectives. Alongside this, how this is affecting the frontline staff and their welfare.

It will be useful to see how the Trust plans to evidence how patients/user feedback is used to inform its work.
Other issues

Equality Issues
We would to see what the Trust is doing to improve the outcome of mental-health burden on black, minority ethnic communities (BME). In addition there is no mention of the mental health needs of the refugee communities. It is important to specifically address these issues because there has been a lot of discussion and issues around this. We are aware this requires multi-agency approach and the challenges.

In summary, we realise that SLaM are working across multiple boroughs and sites and there are operational, performance differences, which is challenging.

However, we would like to see stronger emphasis on patient-centred care across all its services and reflected in its improvement plans. Alongside these developments, more harmony, integration or linked priorities to increase its impact.
Healthwatch Southwark, Lambeth, Bromley & Lewisham

Responses to this Quality Account were requested from the Local Authority Overview and Scrutiny Committees of the four Boroughs; Lambeth, Southwark, Lewisham and Croydon on the 14th April 2015. No comments were received by 28th May 2015.

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.

Monitor 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 2014/15;
- The content of the Quality Report is consistent with internal and external sources of information including:
  - Board minutes and papers for the period April 2014 to May 2015, including:
    - Papers relating to Quality reported to the Board over the period April 2014 to May 2015;
    - Feedback from commissioners dated 07/05/2015
    - Feedback from Governors 19/05/2015
    - Feedback from local Healthwatch organisations 18/05/2015
    - 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 2014/2015
    - 2014 national patient survey results
    - 2014 national staff survey results
    - The head of internal audit’s annual audit opinion over the Trust’s control environment dated 15/05/2015
    - 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 Monitor’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

Roger Paffard
Chair, South London and Maudsley NHS Foundation Trust

Dr Matthew Patrick
Chief Executive, South London and Maudsley NHS Foundation Trust
Independent auditor’s 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 assurance engagement in respect of South London and Maudsley NHS Foundation Trust’s quality report for the year ended 31 March 2015 (the ‘Quality Report’) and certain performance indicators contained therein.

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 2015, 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.

Scope and subject matter

The indicators for the year ended 31 March 2015 subject to limited assurance consist of the national priority indicators as mandated by Monitor:

Minimising Delayed Transfers of Care; and Access to Crisis Resolution Teams.

We refer to these national priority indicators collectively as the ‘indicators’.

Respective responsibilities of the directors and auditors

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’ issued by Monitor.

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’;

- the quality report is not consistent in all material respects with the sources specified in the detailed guidance; 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’ and the six dimensions of data quality set out in the ‘Detailed guidance for external assurance on quality reports’.

We read the quality report and consider whether it addresses the content requirements of the ‘NHS foundation trust annual reporting manual, 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 April 2014 to 28 May 2015;
- papers relating to quality reported to the board over the period April 2014 to 28 May 2015;
- feedback from Commissioners, dated April 2015;
- feedback from governors, dated 19/5/2015;
- feedback from local Healthwatch organisations, dated 18/5/2015;
- the trust’s complaints report published under regulation 18 of the Local Authority Social Services and NHS Complaints Regulations 2009;
- the national patient survey;
- the national staff survey;
- Care Quality Commission Intelligent Monitoring Report dated 4/3/2015;
- the Head of Internal Audit’s annual opinion over the trust’s control environment dated 15/5/2015; and
- any other information included in our review.

We consider the implications for our report if we become aware of any apparent misstatements or material inconsistencies with those documents (collectively the ‘documents’). Our responsibilities do not extend to any other information.

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.

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;
- testing key management controls;
- limited testing, on a selective basis, of the data used to calculate the indicator back to supporting documentation;
- comparing the content requirements of the ‘NHS foundation trust annual reporting manual’ to the categories reported in the quality report; and
- reading the documents.

A limited assurance engagement is smaller 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 which 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’.

The scope of our assurance work has not included testing of indicators other than the two selected mandated indicators determined locally by South London and Maudsley NHS Foundation Trust, or consideration of quality governance.

Conclusion

Based on the results of our procedures, nothing has come to our attention that causes us to believe that, for the year ended 31 March 2015:

- 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’;
- the quality report is not consistent in all material respects with the sources specified in the detailed guidance; and
- the indicators in the quality report subject to limited assurance have not been reasonably stated in all material respects in accordance with the ‘NHS foundation trust annual reporting manual’.

Deloitte LLP
Chartered Accountants
St Albans, United Kingdom
28 May 2015
Notes
If you would like a large print, audio, Braille or a translated version of this leaflet please ask a member of staff.